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IN THE

Supreme Court of the United States

OCTOBER, 1975

No. 75-1041

MT. SINAI HOSPITAL OF GREATER MIAMI, INC., *Petitioner*

v.

FORREST D. MATHEWS, SECRETARY OF HEALTH, EDUCATION & WELFARE, AND BLUE CROSS OF FLORIDA, INC., *Respondents*

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Mt. Sinai Hospital of Greater Miami, Inc. (Mt. Sinai) petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit entered in this cause on August 8, 1975.

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[1] At the time this case was originally filed, Caspar Weinberger was the Secretary of Health, Education and Welfare and hence was a named Defendant; he has since resigned and his successor is named as Respondent herein.

DECISIONS BELOW

The initial opinion of the Court of Appeals (Appendix, pp. 1a-26a) is reported at 517 F.2d 329; its opinion on Mt. Sinai's Petition for Rehearing (Appendix, pp. 27a-28a) is reported at 522 F.2d 179. The Court of Appeals reversed the decision of the United States District Court for the Southern District of Florida, whose opinion is reported at 376 F. Supp. 1099.

JURISDICTION

The judgment of the Court of Appeals was entered on August 8, 1975. On August 22, 1975, Mt. Sinai filed a Petition for Rehearing and Petition for Rehearing *en banc*. These petitions were denied by the Court of Appeals on November 3, 1975. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND CONSTITUTIONAL PROVISIONS INVOLVED

This case involves the Medicare Act, which is Title XVIII of the Social Security Act. [42 U.S.C. 1395 through 1395pp, and 1320c through 1320c-19.] The Medicare Act became effective on July 1, 1966 and, as of the time this controversy arose in 1973, the Medicare Act had been amended in October 1972. Also involved is the Fifth Amendment to the United States Constitution. The pertinent Constitutional and statutory provisions are set forth in the Appendix hereto at pp. 29a to 38a.

THE PARTIES AND THE NATURE OF THE DISPUTE

Mt. Sinai has, for many years, been a general and nonprofit hospital. When the Medicare Act became effective on July 1, 1966, many of Mt. Sinai's patients

became, and over the years have been, Medicare beneficiaries entitled to hospital insurance under that program. The Medicare Act is administered by the Secretary of the Department of Health Education & Welfare ("HEW") through its Social Security Administration, acting in conjunction with private insurance companies known as intermediaries—in this case, Blue Cross of Florida, Inc. ("Blue Cross"). This injunction suit was instituted by Mt. Sinai against Respondents HEW and Blue Cross to enjoin them from withholding more than $6.38 million of Medicare payments to which Mt. Sinai would be entitled. The District Court entered a permanent injunction; the Court of Appeals reversed. The dispute herein arose as follows.

In 1973, Respondents advised Mt. Sinai that they would begin immediately to withhold a portion of all subsequent Medicare payments otherwise due to Mt. Sinai, until they thereby recouped from the hospital a total of $6,380,587.49. According to Respondents, this amount represented the total of a statistically computed fixed percentage of each of the many thousands of separate Medicare payments made to Mt. Sinai throughout the July 1, 1966 to December 31, 1971 time period. Respondents contended that this $6,380,587.49 represented the amount which they statistically computed as having been paid to Mt. Sinai, during those five and one-half years, for services which were medically unnecessary, and, as a result, Respondents contended that they had the power to recoup those funds.

During the July 1, 1966 to December 31, 1971 time period, the medical services provided by Mt. Sinai to Medicare patients were those prescribed by physicians;

and, in each instance, the judgment of the physician as to the medical necessity of the prescribed treatment was subject to review by Respondents on a prepayment basis. Although, as required by the Act, every one of these many payments (totaling $6.38 million) had been originally approved by Respondents on a case-by-case basis throughout the said five and one-half years, Respondents nevertheless contended below that they have the *perpetual* right to repudiate those prior approvals at any time, to recoup from the hospital any payments which Respondents might now deem to have been previously made for unnecessary medical services, and to effect that recoupment by unilaterally withholding otherwise due funds, from the hospital, without the hospital having the right to either an administrative hearing or judicial review.

While the $6,380,587.49 relates to the period from July 1, 1966 to December 31, 1971, Respondents also threatened to make the same kind of statistically based determination, and thereupon to recoup funds, for years after 1971; but since Respondents contended that there is no time limit on their right to make such a determination and thereupon to withhold otherwise due funds, that computation for post-1971 periods had not yet been made when this suit was filed.

The basic dispute is whether hospitals may rely on HEW's inital determinations that the hospital services, prescribed by attending physicians, were medically necessary and therefore covered by Medicare—*i.e.,* to be paid by the patients' Medicare insurance rather than by the patients themselves. If, after years of participation in the Medicare program, hospitals are to learn that they cannot so rely and that all prior payment decisions are forever subject to change on the

subjective and judgmental grounds of medical necessity, all of the many thousands of Medicare providers will be forced to exist under the perpetual threat of a unilaterally implemented administrative recoupment of staggering proportions; and when that threat materializes, as it did for Mt. Sinai, those hospitals may be forced not only to refund overwhelming sums of money to which they were originally entitled, but also to become the ultimate insurer of the patients who received the services at the instructions of their attending physicians.

QUESTIONS PRESENTED

This dispute, the nature of which has been described immediately above, involves the following questions which are of a contining nature and which govern one of HEW's key functions in administering the Medicare program:

1. Where a hospital follows the instructions of attending physicians and provides medical services to Medicare patients, thereby becoming entitled to payment from either the patients or their insurer Medicare; where HEW is required by the Medicare Act to determine, before payment, whether the services were medically necessary and thus covered by Medicare insurance; and where HEW approves and makes Medicare insurance payments for all or part of the patients' hospital bills, does HEW have the implied power, exercisable at any time perpetually thereafter as the Court below held,

(a) to repudiate its prior payment determinations;

(b) to make a postpayment determination or redetermination that the hospital services, pre-

scribed by the physicians, were medically unnecessary;

(c) to claim, from the hospital, a refund of the payments made for those services; and

(d) to satisfy its claim by withholding other funds unquestionably due to the hospital?

2. If HEW has the implied power to repudiate its prepayment determinations and to make a postpayment determination that previously paid for hospital services were medically unnecessary, may it make such a postpayment determination without complying with the express statutory and regulatory requirements applicable to the making of such a determination before payment?

3. If a hospital may ever be liable for the refund of Medicare payments where the sole basis is a postpayment determination that an attending physician prescribed medically unnecessary services, may that liability be administratively determined and then satisfied administratively by recoupment, when the result is to deprive the hospital of its right to pursue reimbursement from the patient and thus to make the hospital the ultimate insurer of the costs of the prescribed services?

4. If, as the Court below held, a hospital, under the circumstance here involved, may be forced to refund Medicare payments even if it has no right to pursue reimbursement from the patient, does this loss of funds, to which the hospital was originally unquestionably entitled, constitute a deprivation of property without due process of law in violation of the Fifth Amendment?

5. Does the Medicare Act violate a hospital's Fifth Amendment rights if it impliedly authorizes such a recoupment power without also providing a hospital with procedural due process safeguards?

STATEMENT OF THE CASE

A. Introduction

As more fully set forth in the REASONS FOR GRANTING THE WRIT *infra*, not only is the decision below erroneous, but the ramifications of that decision, involving substantial public interest questions, go far beyond this one case and have a direct and virtually incalculable impact upon the administration, feasibility and success of one of this country's major domestic programs—Medicare.

As indicated in the decisions of both Courts below, the questions herein cannot be answered on the basis of the language or interpretation of any one particular section of this lengthy, complex and, in certain respects, ambiguous Medicare Act. Instead, the answers require a difficult interpretation of a number of interrelated sections of the Act, against the background of the structure of the Act, its purposes, legislative history and practical effects.

Although the present case involves payment years which fall under the Medicare Act as originally enacted rather than as amended in October 1972, the issues herein are of a continuing nature. First, neither HEW nor the Court below recognized any time limitation on recoupments from hospitals. Therefore, all hospitals are under a continuing threat of recoupment in future years based on payments received from the inception of Medicare until at least the end of 1971. Second, since

the Fifth Circuit found an implied recoupment power outside the Medicare Act, there is an unresolved question whether such power can co-exist with the October 1972 amendments for periods either before or after 1972. For itself, HEW has answered this question by expressly threatening to pursue the same contested course of action against Mt. Sinai not only for the period of the first 10 months of 1972, but also for periods thereafter. [R. 106-107.]

Consequently, not only does the erroneous decision below have a staggering direct impact upon Mt. Sinai, but the decision will also determine how a basic aspect of the Medicare program will be administered nationally in the future. It is no exaggeration to say that, for HEW, *Mt. Sinai* is a test case. If the Fifth Circuit's decision stands, recoupment will become an unexpected and disabling consequence of Medicare participation for hospitals across the country.

B. The Medicare Act

Medicare is a national health insurance program which, since its inception on July 1, 1966, has covered eligible beneficiaries, namely persons aged 65 and over; since 1973, it has also covered disabled persons. [42 U.S.C. 426(a) and 1395c.] The Act is divided into two parts: under Part A, the eligible beneficiaries are insured for hospital and related post-hospital services [42 U.S.C. 1395c-1395i-2], which insurance is funded through payroll deductions contributed to the Federal Hospital Insurance Trust Fund [42 U.S.C. 1395i]; under Part B, the supplementary medical insurance program, eligible persons are insured for other medical services such as those of physicians, but this insurance coverage is optional and requires the beneficiary to

enroll in the program and pay a monthly insurance premium which is matched by a federal contribution. [42 U.S.C. 1395o-1395s.] This case involves questions concerning the substantive and procedural rights and relationship between hospitals and HEW under Part A of the Medicare Act.[2]

The Medicare Act does not relieve an eligible beneficiary of his personal obligation to pay for medical services which he receives; Medicare, as the insurer, merely pays to, or for the benefit of, the patient a part of that patient's medical expenses, and the patient must pay the balance. For example, under Part A, if a Medicare patient is hospitalized for a covered service, there are certain amounts in the nature of deductibles or co-insurance which Medicare will not pay [42 U.S.C. 1395e]. There are also limits in terms of the maximum number of hospital days (150 per illness) which Medicare will cover [42 U.S.C. 1395d]; and if the services rendered were of the type not covered by insurance [42 U.S.C. 1395y], Medicare has certain rights not to pay.

In order to effectuate the claims and payment process, the hospital submits the appropriate insurance forms to HEW through the latter's intermediary. Before payment, HEW and its intermediary are required to process those forms and determine whether the patient is eligible for insurance, the amount of insurance to which he is entitled and whether the services rendered were covered by insurance, including whether they were medically necessary. [42 U.S.C. 1395ff(a); 20

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[2] The case at bar was argued to, and decided by, the Court of Appeals concurrently with the case of *Szekeley* v. *Weinberger*, 517 F.2d 345, a Part B case involving a physician and wherein the Court below reached the same result.

C.F.R. 405.701 *et seq.*] To the extent HEW approves payment, such payment, though made directly to the hospital, is deemed by the Medicare Act to have been made to the patient. [42 U.S.C. 1395gg(a)(1)(A).] The patient, therefore, is the beneficial recipient of that payment since it is his insurance paying his bill, and it is his debt to the hospital which is being satisfied *pro tanto*.

Moreover, a hospital may bill, and receive payment for, no more than the cost of the covered services provided to a Medicare patient. [42 U.S.C. 1395f(b) and 1395x(v).] [3] Once HEW determines that the service is covered and that a Medicare payment is to be made therefor, the hospital must accept that payment from HEW and may not bill the patient except for the amounts not paid by HEW for that service, such as the deductible and co-insurance amounts noted *supra*. [42 U.S.C. 1395cc(a)(1)(A).]

If HEW refuses to pay for all or any part of the patient's hospital bill, the patient, since he must pay the hospital, has the right to contest with HEW the refusal to pay; in this regard, the patient (but not the hospital) has the right to an adversary type administrative proceeding if more than $100 is involved and to judicial review if more than $1000 is involved. [42 U.S.C. 1395ff(b).]

C. Statement of Facts

Mt. Sinai has been a qualified provider since the July 1, 1966 effective date of Medicare. It is a general

[3] After the close of the hospital's fiscal year, a cost audit is performed to determine if the hospital's costs for Medicare services equaled the payments made therefor; if not, an adjustment is made to equalize the two. [42 U.S.C. 1395g.]

and nonprofit 646-bed hospital and, as the record reflects, has operated at a substantial loss, relying heavily on donations. [R. 306.] [4, 5] Not only is it one of the largest hospitals in the Southeast, but it is located in an area (Miami Beach, Florida) heavily populated by persons eligible for Medicare; it also specializes, and enjoys a national reputation for leadership, in, *inter alia*, medical fields relevant to the problems of persons aged 65 and over and hence serves Medicare patients referred from other areas of the United States. [R. 5, 6]. Consequently, a large percentage of its patients has consisted of Medicare beneficiaries. [R. 304.]

During the entire period from July 1, 1966 to the present, Mt. Sinai has provided to Medicare patients the services prescribed by the patients' attending physicians. As a qualified Medicare provider, it submitted insurance forms and information to HEW through the latter's intermediary, Blue Cross. Those forms were then processed by Respondents; to the extent approved, the reimbursement claims were paid to Mt. Sinai by HEW [R. 9, 22], which payments, as noted, were only for the cost of the rendered services.

In the Spring of 1973, HEW made a demand upon Mt. Sinai to refund $6,380,587.49 from the Medicare payments which had been made by HEW to Mt. Sinai for services during the entire period from July 1, 1966

[4] Mt. Sinai's 1972 loss was $946,638, and it had budgeted, for 1973, a loss of $1,933,176. (R. 306)

[5] References to "R" are to the record appendix which was before the Court below. While those record references are not reproduced in the Appendix to this Petition, the references have been inserted in order to alert Respondents to the specific portions of the record relied on by Petitioner in asserting the facts herein.

(the first day of Medicare) through December 31, 1971. HEW also stated that it would demand an additional refund for post-1971 time periods, but that the amount had not yet been calculated. [R. 106-107.] To effect this refund, HEW advised that it would begin holding back a percentage of Medicare payments otherwise unquestionably due to Mt. Sinai for future, current and recently provided, but unpaid for, services until the full $6,380,587.49 was recouped. [R. 34, 106-107.]

In making this demand, HEW did not contend that Mt. Sinai had committed any fraud. Nor has HEW contended that Mt. Sinai made any misrepresentations of fact in submitting insurance forms and receiving payment. Moreover, it is admitted that Mt. Sinai rendered every service for which it was paid and that it has been paid no more than the correct amount, namely the cost of those services rendered to Medicare patients at the physicians' instructions. The only basis for HEW's demand is its contention that a part of the services rendered to Medicare patients was medically unnecessary.

HEW does not contend that the hospital could or should have refused to provide the services prescribed by the patients' physicians. Instead, the thrust of HEW's position is that it was an error in medical judgment for the physician to have prescribed certain hospital services, that it was, in turn, an error for HEW to pay for those services and that HEW should now have the power, years later, to reopen all cases going back to July 1, 1966 without limitation as to time or amount, contradict the initial medical judgment made by the physican and reclaim, from the hospital, the amounts paid for those services, even though the hospital was unquestionably entitled to such payment, whether from the patient of Medicare.

HEW's demand for a refund of $6,380,587.49 was based on a determination which was made by it and Blue Cross, essentially *in camera*. In two separate sessions, one in December 1972 and the other in January 1973, a group of unidentified doctors reviewed the charts of 710 patients who had been hospitalized at Mt. Sinai in 1970, which charts did not contain the patients' complete medical records. According to HEW, these doctors (without consulting the patients, the patients' other medical records, the attending physician or the hospital) spent an average of 10 to 15 minutes reviewing each such chart, and, without any guidelines from HEW as to the legal standards to be applied under the Medicare Act, concluded that a portion of the hospital services prescribed for 283 of these patients was unnecessary, which services were essentially the tailend days of the hospital stays. [R. 133-136, 158, 167.] Arriving at an arithmetical percentage of alleged unnecessary services to total services for those selected patients in 1970, HEW then applied that percentage across the board to all the services rendered to all (more than 62,800) Medicare patients treated by Mt. Sinai from July 1, 1966 to December 31, 1971, which percentage it priced at $6,380,587.49. [R. 12, 98, 138.]

When Mt. Sinai asked for the pertinent information relating to these conclusions, such as the identities and qualifications of the physicians who allegedly determined that a portion of the services were unnecessary, as well as the facts on which the decisions were based, HEW absolutely refused to give the information [R. 35-38, 52-53, 127, 135, 137.] In addition, Respondents admitted that they had never gone through another procedure quite parallel to that followed with respect to Mt. Sinai [R. 122] and that they did not know

everything that had been done during the so-called review [R. 123]; and just as they refused to discuss in any way the basis of the medical determinations [R.168-169], Respondents refused even to say whether or not they had a full understanding of the methodology used. [R. 170-171.]

While Mt. Sinai and the Respondents had two informal meetings, which HEW elects to call hearings, the following statement by a representative of the Respondents, when he was asked during a meeting for meaningful information relating to HEW's claim, is typical of the totally uncommunicative position taken by Respondents [R. 182].

> . . . I don't want to repeat myself, but again we have not come here today to be questioned by Mt. Sinai. The purpose of this meeting is not to furnish information for Mt. Sinai to make a determination.

Mt. Sinai attempted to rebut HEW's position [R. 39-48, 332-348], but it was to no avail. Respondents refused to provide an administrative hearing, denied that judicial review was available and threatened to withhold funds starting immediately until the full $6,380,587.49 was recouped, notwithstanding the fact that this approach totally circumvented the prepayment review procedures established by 42 U.S.C. 1395ff and 20 C.F.R. 405.701 *et seq.*

Given HEW's threat and mode of proceeding, Mt. Sinai filed suit on May 10, 1973 to enjoin the withholding of funds admittedly due to and urgently needed by it to continue the level of medical services it was then providing already at a loss. Mt. Sinai's attempt, through discovery, to ascertain the facts underlying HEW's actions came to naught after HEW objected

thereto on the grounds that the legal issue, i.e., whether HEW had the power it was asserting, could be decided without inquiry into the facts. After an evidentiary hearing, the District Court found that the threatened withholding of funds would cause immediate and irreparable harm not only to the hospital but also to the public because of the potential curtailment of medical services that a withholding of funds would cause.[6] The District Court also held that the statutory procedures set forth in the Medicare Act provided the sole and exclusive means for HEW to make coverage determinations and payment adjustments, and that nothing in the Statute authorized HEW's threatened retroactive recoupment of funds from Mt. Sinai. Accordingly, it permanently enjoined HEW from the threatened withholding action.

The Court of Appeals reversed, holding that the Medicare Act *impliedly* empowered HEW to recoup funds from a hospital, even if the only basis for such recoupment was a new judgment as to the medical necessity of treatment prescribed years before; and it held that this implied power was not affected by the Medicare Act, even though that Court acknowledged that the exercise of such power was inconsistent with certain provisions of the Act itself.

REASONS FOR GRANTING THE WRIT

A. The Importance of the Issues

The decision of the Court below is an erroneous interpretation of the Medicare Act and permits a result which, in violation of the Fifth Amendment, puts Mt.

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[6] See fn. 4, p. 11, *supra*. Given Mt. Sinai's negative cash flow there was testimony before the District Court that the threatened withholding of funds by HEW would have a catastrophic effect on the hospital and its ability to provide services. [R. 220.]

Sinai in jeopardy of losing more than $6.38 million in Medicare reimbursements to which it is entitled by law for the cost of services rendered to Medicare beneficiaries. But beyond the $6.38 million effect on Mt. Sinai, the decision below will have a profound impact upon the administration and operation of Medicare nationally.

The basic dispute is whether, in administering the Medicare program, HEW must follow the procedures that are expressly established under the Medicare Act, and which attempt to balance the competing substantive interests of Medicare beneficiaries, Medicare providers and Medicare insurance funds under procedural due process safeguards; or whether HEW may, on a common law recoupment theory, circumvent the procedures and totally upset that balance by creating a system of retroactive review and recoupment which is neither expressed in, nor consistent with, the Act.

The Fifth Circuit, by implication, found a non-statutory power, under which power HEW may forever into the future contest the medical necessity of hospital treatment provided as far back as July 1, 1966, and then reclaim, from hospitals, the amounts attributable to the allegedly unnecessary services which the hospital did no more than provide, pursuant to the orders of an attending physician. This power, with its *perpetual* threat to hospitals, creates an immense area of potential uncertainty and dispute under the Medicare program generally. For the period from July 1, 1966 through 1971 alone, thousands of hospitals, millions of patients and billions of dollars will forever be subject to this power, as the following statistics reflect:[7]

[7] These statistical charts are derived from data provided by HEW and from HEW's published annual reports on the Medicare program.

FOR THE UNITED STATES[8]

Year	Eligible Beneficiaries[9]	Participating Hospitals[10]	Medicare Payments[11]
1967	19,022,707	6,750	$2,192,341,502
1968	19,309,572	6,753	3,066,963,782
1969	19,586,536	6,712	3,712,775,897
1970	19,838,866	6,670	4,246,048,000
1971	20,230,121	6,642	4,808,831,000
Total 1967-1971			$18,026,960,181

Even if the decision below were viewed as affecting only the Medicare program as administered in the Fifth Circuit, the potential impact of the Court of Appeals decision is immense, as indicated by the following data:

FOR THE FIFTH CIRCUIT[12]

Year	Eligible Beneficiaries	Participating Hospitals	Medicare Payments
1967	2,827,651	1,169	$260,222,005
1968	2,888,783	1,178	396,856,915
1969	2,972,555	1,194	480,787,064
1970	3,053,286	1,184	582,096,000
1971	3,177,390	1,212	659,765,000
Total 1967-1971			$2,379,726,984

[8] Not including outlying possessions.

[9] As of January 1 of each year, except for 1967, which covers the 18-month period from July 1966 through December 1967.

[10] As of July 1 of each year.

[11] By fiscal year, based on interim reimbursements, for short-stay in-patient hospital benefits.

[12] Compiled from statistics reported for the States of Alabama, Florida, Georgia, Louisiana, Mississippi and Texas.

Every one of the hospitals, hospital patients and dollars involved in Medicare through the end of 1971 is therefore subject to the unlimited power found to exist by the Court below. Given the above statistics, the potential for perpetual controversy is awesome. The sheer administrative effort and financial resources needed to assert and contest retroactive recoupment claims will be enormous, as will be the disruptive effect, regardless of how such claims against hospitals are eventually resolved. And the financial impact of such a recoupment campaign, in which Mt. Sinai stands as the test case, could be devastating for hospitals generally, as well as result in the hospitals being financially unable to maintain the level or scope of services required by the public. [R. 61, 244.]

The mere continuing threat of massive recoupment (which the decision below permits) nullifies reliance on past medical judgments already approved, makes hospital planning and budgeting difficult, if not impossible, and could well discourage hospitals from future participation in the Medicare program, because of the inordinate and uncontrollable financial risk involved.

The October 1972 amendments added to the Medicare Act a number of important changes, among which were the additions of 42 U.S.C. 1395pp and an addition to the then existing 42 U.S.C. 1395gg. The open question is whether these 1972 additions create a new and greater exposure on the part of hospitals or whether they create an exposure in addition to, or in limitation of, a common law recoupment right which the Court below found to be impliedly permitted by the original Act. This question is further complicated by the addition of 42 U.S.C. 1320c through 1320c-19 which established the so-called Professional Standards Review Organization ("PS

RO") and which relate to the question of handling medical necessity questions *vis-a-vis* the hospital. [42 U.S.C. 1320c-9.]

The Court below failed to come to grips with the interrelationships of these various sections, leaving in doubt the question of where ultimate exposure resides, and its simplistic reliance on an alleged common law recoupment theory creates confusion and hence uncertainty. As noted, *supra*, p. 6, HEW has threatened to apply the same technique against Mt. Sinai for years after 1971, indicating that the October 1972 amendments to the Medicare Act do not, in HEW's view, affect the common law recoupment power held by the Fifth Circuit to be implied in the Medicare Act.

The decision below, therefore, has extensive and continuing ramifications for the period prior to the 1972 amendments, and it has created inconsistencies and uncertainties relative to the present and future administration of the Act under the 1972 amendments.

B. The Decision Below Is Erroneous

1. The Medicare Act neither expressly nor impliedly permits HEW, on a common law recoupment theory, to recover funds from a hospital, solely on the basis of a retroactive determination by HEW that hospital services, previously prescribed by physicians and paid for by Medicare, were medically unnecessary.

Both Courts below recognized that the Medicare Act nowhere *expressly* authorizes HEW to do as it threatened here. The Court of Appeals, however, held that a power to recoup from a hospital was *impliedly* authorized by the Act, and, in so doing, that Court disregarded the authoritative statements of Government representatives to the effect that *no* such power exists. For example, testifying before Congress in 1970, Social Security Administrator Ball stated that HEW (absent

of course fraud or other independent claim) had no such power under Medicare, even for abuses of the program, and that its power was limited to a case by case prepayment review. See Hearings on H.R. 1 before the Committee on Ways and Means of the House of Representatives, 91st Cong., 2d Sess. 154 (1970). The House Ways and Means Committee stated that same conclusion in 1970 [H. Rep. No. 91-1096, 91st Cong., 2d Sess. 43 (1970)] and in 1971 [H. Rep. No. 92-231, 92d Cong., 1st Sess. 98-100(1971)] as did the Senate Finance Committee in 1972 [S. Rep. No. 1230, 92d Cong., 2d Sess. 200 (1972)]. The Justice Department, in its Brief to the Second Circuit in *Kingsbrook Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973), made the same representation as to Congresssional intent when it stated:

> *Nor would it be reasonable to assume that Congress intended to keep open all accounting periods and to continually change the amounts for past years to which a provider was entitled.* Moreover, a change in HEW's policy or regulations would not necessarily mean that a provider would be entitled to additional money; it may well be that the change could yield an "overpayment" for a particular prior year—indeed, it appears that in this case appellant did receive an "overpayment" in 1966 if the change is retroactively applied. *Congress could not have intended to put providers in continuing jeopardy of having to return potentially large sums of money previously determined to be due them.* (Brief, pp. 26-27) (Emphasis supplied.) [13]

[13] *Kingsbrook* was a cost accounting case, not a case involving coverage questions such as medical necessity. There are different statutory provisions dealing with cost accounting and which allow certain retroactive accounting adjustments for determining the total cost for which a hospital may be reimbursed. However, Justice's reference to Congressional intent is applicable to coverage cases as well.

In addition to the above statements, that no such power exists, HEW itself could not find a proper source for the recoupment power it asserts here. Although Medicare became effective on July 1, 1966, it was not until May 1972 (almost six years later and on the eve of the 1972 amendments) that HEW first promulgated a regulation expressing the right to recover funds, and, in so doing, it did not rely on any common law recoupment power.[14] The only substantive authority on which HEW predicated its authority was 42 U.S.C. 1395g which, as *both* Courts below held, *did not* authorize the recoupment right asserted by HEW. Not until HEW's action was challenged by Mt. Sinai, in what has become a test case, did the Justice Department urge the common law as an alternative source of HEW's asserted recoupment power. In view of the fact that HEW waited so long to express such a recoupment power by regulation and then was unable properly to locate the source of that power, there is all the more reason to doubt the very existence of that power which the Court below could find only by implication.

And even the Justice Department, in making its common law recoupment argument below (contrary to its argument in *Kingsbrook*), was internally inconsistent and hence inconclusive as to what the Medicare Act impliedly provides. For example, in its Opening Brief below (p. 24), the Justice Department argued that HEW *was not required* to recoup funds previously paid for unnecessary services, while later in the same Brief (p. 33), it argued that HEW *was required* to recoup

[14] 37 Fed.Reg. 89 (Jan. 5, 1972), proposing adoption of 20 C.F.R. 405.370 *et seq.* The regulations were adopted as proposed. 37 Fed. Reg. 10722 (May 27, 1972).

such funds. Such inconclusiveness, like HEW's erroneous view of the source of its power, does little to engender confidence in the correctness of HEW's present position and the decision below, especially in view of the contrary pronouncements noted, *supra*.

The Fifth's Circuit's decision is also inconsistent with, and violative of, certain express provisions in the Act itself. While the decision below assumes that HEW must be able to avoid, at all costs, paying for any service which is medically unnecessary, the Act contemplates otherwise. For example, under the Act, a hospital must maintain an in-house utilization review committee of physicians to establish procedures for avoiding unnecessary care.[15] If that committee determines that a particular hospital stay for a patient is no longer necessary, it is required to notify the hospital and the patient's physician. [42 U.S.C. 1395x(k)(4).] Even after such a determination and notice, Medicare hospital benefits are still to be paid by HEW up to the fourth day following the hospital's receipt of that notice. [42 U.S.C. 1395f(a)(7).] Under Medicare, therefore, it is erroneous to start with the assumption that any payment for an unnecessary service can and must be recouped; yet HEW and the Court below not only start with this assumption, but, by retroactive recoupment, they would even wipe out, by implication, the statutory grace period by recouping funds paid for

[15] Ironically, Mt. Sinai's committee, during the years here involved, had not only been praised by Respondents but was referred to as a paragon for other hospitals to emulate. [R. 8-9, 22, 43-44] For a description of the role of in-house utilization review, see *Hultzman* v. *Weinberger*, 495 F.2d 1276 (3rd Cir. 1974).

every allegedly unnecessary day at the hospital, and without any prior notice at all.[16]

As further evidence that it did not intend to make make hospitals retroactively accountable for the medical judgments of attending physicians, Congress provided that the patients' hospital claims be reviewed by HEW before payment on a current and case-by-case basis. [42 U.S.C. 1395ff(a).] HEW has implemented this requirement by elaborate regulations. [20 C.F.R. 405.701 *et seq.*] If HEW determines to reject payment, in whole or in part and for any reason, including the lack of medical necessity, it must entertain a protest from the patient, not the hospital, and it must afford that patient an adversary administrative hearing which is subject to judicial review, provided that certain minimum dollar amounts are satisfied. The review rights are important to the patient who remains obligated to the hospital. On the other hand, the hospital is not a party to such proceedings because the determination does not affect the hospital's right to payment; it is entitled to payment from either the patient or Medicare.[17] However, this statutory framework, for case-by-case prepayment review of medical necessity and all other

[16] Retroactive determinations and recoupment also would result in unlawful denials of benefits under the days of coverage limitation, since days retroactively determined not to be covered were counted as covered, at the time, in applying the spell-of-illness limitation. [42 U.S.C. 1395d]

[17] A memorandum from the Bureau of Health Insurance to the Office of General Counsel/SSA dated December 18, 1975 states—"[T]here is no requirement for an adversary type hearing in the law or regulations (or in our claims processing procedures) for providers adversely affected by § 1862(a)(1)—[42 U.S.C. 1395y(a)(1)]—denials except for those appeals available to beneficiaries on a bill by bill basis through BHA."

conditions to payment, is entirely circumvented when HEW attempts to recoup retroactively from the hospital, since HEW denies that the requirements of 42 U.S.C. 1395ff and 20 C.F.R. 405.701 *et seq* (promulgated thereunder) are available to a provider.[18] One may well ask why Congress would, on the one hand, have *expressly* provided for an elaborate procedure for contesting medical necessity *vis-a-vis* the patient on a case-by-case while, at the same time, *impliedly* giving HEW the incompatible power totally to negate that approach by paying first and recouping later from the hospital. The answer must be that Congress would not have done so.[19]

The decision below, therefore, sanctions an approach and a result which are both different from and inconsistent with the administrative framework established by the Act. And because the hospital may have neither legal nor practical recourse against the patient for reimbursement, the decision below erroneously transforms the hospital into the insurer, penalizing the hospital with staggering liability because, with no prior notice or warning, it did no more than follow the instructions of the patient's attending physician.

The decision to imply such a recoupment power against a hospital, exercisable at any time, in per-

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[18] But see 42 U.S.C. 1395pp. added in the 1972 amendments. HEW has not relied upon, or proceeded under § 1395pp in the present case.

[19] In *T.I.M.E., Inc.* v. *United States*, 359 U.S. 464 (1959) and *United States* v. *Associated Transport, Inc.*, 505 F.2d 366 (D.C. Cir. 1974), this Court and the Court of Appeals for the District of Columbia, respectively, held that the existence of statutory procedures precluded the Government from resorting to common law procedures which were incompatible with the statute.

petuity, could only have been based on the highly simplistic assumption that Congress intended to elevate the preservation of Federal funds above all other considerations in the administration of the Medicare program; but this assumption is contrary to the broad remedial purposes of the Act. Cf. *Sowell* v. *Richardson,* 319 F.Supp. 689, 691 (D.S.C. 1970). As noted above, the Act expressly requires the payment of hospital services, during a grace period after actual notice, even when hospitalization is unnecessary; and both the Congress and the Courts have recognized that the paramount interest under the Act is not perfect efficiency but instead is to make medical services available to a certain segment of society,[20] based on the medical judgment of the patient's physician,[21] without interference in the providing of medical treatment,[22] and without deterring hospitals from providing the best of modern care.[23]

Instead of making the financial interests of the federal fund of superior importance to all other considerations, Congress attempted to accomplish a delicate balancing of competing interests in what was then a most controversial program; the prepayment review procedures of 42 U.S.C. 1395ff reflect that attempt. As far as the patient and hospital are concerned, a current review on a case-by-case basis might result in HEW not paying a portion of the hospital bill.[24] However,

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[20] *Hultzman* v. *Weinberger*, 495 F.2d 1276 (3rd Cir. 1974); *Sowell* v. *Richardson, supra.*

[21] 1965 U.S. Cong. & Adm. News 1986; 42 U.S.C. 1395f(a)(3).

[22] 42 U.S.C. 1395.

[23] 1965 U.S. Cong. & Adm. News 1967-1968.

[24] The data recently supplied by HEW to Mt. Sinai indicates that HEW has refused payment on grounds of lack of medical necessity as well as on other bases.

a current rejection identifies the patient and gives the hospital the opportunity to recover from the patient who, in turn, may contest coverage with HEW as noted *supra*. Even if the hospital cannot recover from the patient because of the patient's inability to pay, the loss is relatively small and the incident permits the hospital, physician and HEW to focus upon a current practice, engage in mutual education and either moot the dispute or avoid a recurrence.[25] It permits treating the issue when the facts are fresh and witnesses and evidence are available, and it lets a hospital rely on such determinations without proceeding under the ever present and ominous threat of a potentially catastrophic liability.

By contrast, retroactive recoupment eliminates reliance, creates uncertainty and an inordinate financial risk, nullifies the statutory grace period, raises the issues long after they have become stale and either impedes or precludes the hospital from seeking payment from the patient, all without any of the educational benefits of the prepayment review approach. There is, therefore, a vast difference between reviewing medical necessity on a current case-by-case basis and reviewing it on a retroactive basis, and this difference is of vital significance in this case. Congress provided for only the former and hence, notwithstanding HEW's monetary-based arguments, it is unreasonable to conclude that Congress intended to approve practices outside the Act that would undercut the very procedures it enacted, destroy the balance it sought to achieve and create the devastating and unfair burden on hospitals which the decision below contemplates.

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[25] Compare 42 U.S.C. 1395h(b)(1)(B).

In addition to the above, there is a basic flaw in the decision below which, ironically, even the Court of Appeals admitted when it acknowledged that it was creating an anomaly or inconsistency in the Act. As noted, the patient is obligated to bear the cost of his hospital bill if, after a Sec. 1395ff proceeding, HEW's refusal to pay is upheld. The Court below recognized that an implied common law recoupment right conflicted with the Act if it meant that, after HEW's recoupment from the hospital, the hospital could then recover from the patient, since this would result in the patient being held liable without the benefit of Sec. 1395ff procedures which, of course, the hospital could not grant; the Court noted that this was a severe anomaly.[26] In its opinion on Mt. Sinai's request for rehearing, the Court below suggested that this anomaly might be resolved if the hospital had no right to seek reimbursement from the patient, thereby resulting in inconsistent coverage determinations—*i.e.*, that HEW may view a particular service as necessary for purposes of establishing the rights of the patient, but as unnecessary for purposes of claiming recoupment from the provider.[27] Not even HEW has contended that such an inconsistency is proper under the Act. Nor has HEW disputed that, under the Act, the patient is liable to the hospital for services not covered by Medicare.[28] To imply a power that creates admitted anomalies or inconsistencies under the Act must be erroneous.

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[26] Opinion, fn. 17 [App. 14a]. Cf. Opinion denying rehearing [App. 27a].

[27] Opinion denying Rehearing [App. 27a].

[28] HEW's Opening Brief below, p. 27.

The Court below, however, based its decision on subsection (b) of 42 U.S.C. 1395gg (as originally enacted) which states no more than that HEW may recover, from a patient, the excess paid "over the correct amount," if the excess cannot be recouped from the provider. While acknowledging that this section does not itself authorize recoupment from a hospital or state when or how it may be done, the Court concluded that the section impliedly assumed a common law right of recoupment against a hospital where HEW retroactively decided it had paid for medically unnecessary services.

In light of what has been said above, the Court's jump to this conclusion was both unnecessary and wrong. The oblique reference in 42 U.S.C. 1395gg (as it was before the 1972 amendments) is no more than a receptacle to pick up claims provided elsewhere, independent of the Medicare Act (to be read in *pari materia*), such as claims which HEW may have for fraud or false statements on the part of the hospital. See *e.g.*, *Peterson* v. *Weinberger*, 508 F.2d 45 (5th Cir. 1975). To the extent that the Court below believed that 42 U.S.C. 1395gg incorporates (but does not create) claims that HEW may have against a hospital *under* the Act as opposed to claims arising from *independent* bases, its ultimate conclusion fails to consider the relationship of 1395gg to the rest of the Act. While the Act does not expressly authorize adjustments against a provider based on retroactive coverage determinations (as both Courts below recognized), it does provide for retroactive (*i.e.*, post-payment) adjustments based on final determinations of the *cost* of services. [42 U.S.C. 1395g.] Thus, where an amount in excess of the correct amount—*i.e.*, the cost—of a service has been

paid, there is a right to recovery from the provider, and Sec. 1395gg requires that that route be pursued first.[29] But where the issue is medical necessity (coverage), no right against the provider exists.

In view of (1) the express pronouncements to the contrary, (2) the erroneous conclusion by HEW as to the source of its alleged power, (3) the inconsistent statements by the Justice Department as to what the law provides, (4) the general purposes and balancing structure of the Act, (5) the devastating result, (6) the notice and three-day grace period provisions, (7) the prepayment review procedures of Sec. 1395ff, and (8) the anomalies and inconsistencies that flow from the decision below, the decision is clearly erroneous to the extent it permits recoupment from a hospital based on medical necessity (as opposed to cost) determinations. If the Fifth Circuit's decision is allowed to stand, the administrative framework enacted by Congress will be emasculated and replaced by an unauthorized administrative framework that denies hospitals their rights under the Medicare Act.

2. Even if common law recoupment were implied in the Medicare Act generally, it would be inapplicable here.

Even if the Court of Appeals was correct in implying a common law recoupment right, its decision is contrary to that right as the Court itself defined it. Relying on *United States* v. *Barlow*, 132 U.S. 271, 280, fn. 10 (1889), the Court below expressly noted that HEW would have no common law right of recoupment (even if in principle that right were available in the context

[29] Note that 42 U.S.C. 1395gg(a) states that any payment to a provider on behalf of an individual is regarded as a payment to such individual.

of the Medicare Act) if the payments, which it sought to recover, had been made because of an error in judgment.[30] Yet, in the case at bar, the sole basis for recoupment is alleged error in judgment as to whether a particular treatment should have been considered medically necessary. The legislative history of the Medicare Act, HEW regulations, and judicial decisions all recognize that the determination of medical necessity is judgmental, and that the attending physician is in the best position to make that judgment. See, *e.g., Hultzman* v. *Weinberger,* 495 F.2d 1276 (3rd Cir. 1974) and 20 C.F.R. 405.1035(g) cited therein; S.Rep. No. 92-1230, 92d Cong., 2d Sess. 295 (1972); and Fifth Circuit Opinion [App. 1a]. This is not a case where a hospital has mistakenly received payment for a service not rendered or where there has been a mistake in identifying the services. This is simply a case of whether HEW may recoup funds previously paid as the result of an alleged error in subjective medical judgment, and hence common law recoupment is inapplicable for that reason alone. Additionally, Mt. Sinai has not been unjustly enriched, having received no more than it was unquestionably entitled to—i.e., the cost of services actually rendered. Finally, recoupment from the hospital is barred by 42 U.S.C. 1395gg (a), under which the hospital is not to be deemed the recipient of the payment sought to be recouped.

3. The decision below violates Mt. Sinai's Fifth Amendment rights.

The hospital's right to payment for services rendered is a property right protected by the Fifth Amendment, yet the decision below would result in a

[30] *Cf. Springdale Convalescent Center* v. *Mathews,* — F.Supp. —, CCH Med. & Med. Guide ¶ 27,559 (N.D. Ga., Sept. 29, 1975).

confiscation of that right. Even if Mt. Sinai has the theoretical legal right to recover from the patients, notwithstanding 42 U.S.C. 1395ff and likely limitations defenses, it would be unable to do so by virtue of HEW's use of an anonymous statistical approach where a part of every patient's services are deemed unnecessary; it is difficult to believe that a patient could, in turn, be held liable to reimburse the hospital as a result of the HEW statistical analysis. Hence, whether the hospital is precluded from its admitted right of recovery because of legal or practical reasons, the net effect of the decision below is to deprive the hospital of property which unquestionably was due it, whether from the patient or HEW, and this deprivation will occur without benefit of time limitation, procedural protection or express statutory authorization. Such a deprivation violates Mt. Sinai's Fifth Amendment rights. *Cf. Springdale Convalescent Center* v. *Mathews, supra; South Windsor Convalescent Home* v. *Weinberger,* — F.Supp. —, CCH Med. & Med. Guide ¶ 24,474 (D. Conn., July 17, 1975).

Moreover, if Congress had impliedly given HEW the perpetual right to recoup, without giving the hospital any procedural or time protections, the chilling effect of the ever present threat created thereby would not only have impacted enough on the practice of medicine so as to violate 42 U.S.C. 1395, but the impact would have been akin to the mandatory influence found to be unconstitutional in *Doe* v. *Bolton,* 410 U.S. 179 (1973) and *Roe* v. *Wade,* 410 U.S. 113 (1973). See also *American Medical Association* v. *Weinberger,* — F.2d — (7th Cir. 1975) (stating that the implementation of a prospective review of medical necessity, although a facially constitutional requirement under the

1972 amendments might be unconstitutional, depending upon the impact it had on the practice of medicine).

The facial constitutionally of the 1972 amendments, to the extent they created a new procedure for current review of medical necessity, was recently upheld by a three judge Court in *Association of American Physicians and Surgeons* v. *Weinberger,* 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd per curiam,* — U.S. —, 44 U.S.L.W. 3295 (November 18, 1975). The basis of that decision was, in part, that the new law contained provisions satisfying procedural due process requirements (notice, hearing and judicial review), did not involve a private insurance company intermediary (which might have a bias or conflicting interest) in the final decision, and did not have an undue impact on the practice of medicine. If such statutory protections are necessary to uphold the facial constitutionality of a prospective case-by-case review approach, then *a fortiori* they should be prerequisites for the validity of a far more onerous retroactive recoupment approach. Since, in the instant case, there are none of these statutory safeguards, the Fifth Circuit's interpretation is constitutionally infirm.

CONCLUSION

The statutory and constitutional issues herein presented have sufficient national importance so as to warrant this Court's review of the erroneous decision below. For the reasons stated, a writ of certiorari should be issued to the Court of Appeals for the Fifth Circuit to review that decision.

Respectfully submitted,

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APPENDIX

Court of Appeals Opinion

APPENDIX

UNITED STATES COURT OF APPEALS,
FIFTH CIRCUIT.

No. 74-2154.

MOUNT SINAI HOSPITAL OF GREATER MIAMI, INC.,
Plaintiff-Appellee,

v.

CASPAR WEINBERGER, Secretary of Health, Education and Welfare, and Blue Cross of Florida, Inc., *Defendants-Appellants.*

Aug. 8, 1975.

* * *

Appeal from the United States District Court
for the Southern District of Florida.

Before BROWN, Chief Judge, and GODBOLD and CLARK, Circuit Judges.

GODBOLD, Circuit Judge:

This case arises from an attempt by the Department of Health, Education and Welfare [HEW] to recoup $6.3 million from Mount Sinai Medical Center ["the hospital"]. This amount was allegedly paid to Mount Sinai for medically unnecessary services and hospital stays provided to beneficiaries under the Medicare hospital insurance system from 1966 to 1971. Before HEW could commence recoupment by putting into effect a partial freeze on future payments to Mount Sinai to offset the amount claimed, the hospital sued for temporary and permanent injunctive relief against the freeze.

HEW's attempt to recoup the funds was based on its theory that the government has a common law right to recoup monies paid out illegally. The District Court

granted temporary relief. Later, after hearing and on cross motions for summary judgment, it accepted Mount Sinai's principal defense that the complex statutory and administrative scheme governing the Medicare program had abrogated the government's right to recoup, and it granted a permanent injunction. 376 F.Supp. 1099 (S.D. Fla., 1974). HEW appeals. We reverse on the recoupment issue and remand for further proceedings.[1]

Mount Sinai is a major provider of services under the Medicare program, the largest in the southeast and, measured in terms of cost of services, more than twice as large as the second largest provider in its state. From 60 to 70 percent of Mount Sainai's patient-days and total billings are now attributable to Medicare.

Allegations of wrongdoing by Mount Sinai in operation of the Medicare program were made in 1972. HEW subjected to review by a peer review committee of doctors a sample consisting of the charts of 710 patients from a single year. The statistical results of the committee's determinations of medically unnecessary hospital stays and ancillary services drawn from this sample were then applied to all years in question, producing a calculated, as opposed to actual, overpayment figure of $6.3 million.

I. The Medicare System

Federal Health Insurance for the Aged, popularly known as Medicare, was enacted by Congress in Title I of the Social Security Amendments of 1965, P.L. 89-97, §§ 101-122, 79 Stat. 286, July 30, 1965, as Subchapter XVIII of

[1] The parties have briefed and argued two substantial issues other than the recoupment question: whether HEW followed properly promulgated regulations in attempting to institute the freeze, and whether in any event the procedures utilized comported with Mount Sinai's Fifth Amendment due process rights. We do not reach these issues, which are for the District Court to rule on in the first instance.

the Social Security Act, codified as 42 U.S.C. §§ 1395-1395*ll* (1970), as amended 42 U.S.C. §§ 1395-1395pp (Supp. III).[2] The system contains two substantively distinct parts, one providing insurance for hospital and related post-hospital services, known as Part A, 42 U.S.C. §§ 1395c-1395i-2 (Supp. III), the other providing insurance for supplementary medical services, primarily physicians' services, known as Part B, 42 U.S.C. §§ 1395j-1395w (Supp. III). This case concerns Part A.[3]

Under Part A, the hospital insurance program, persons aged 65 and older, § 1395c,[4] receive essential hospital services, § 1395d, paid for from a trust fund financed by wage taxes on employees and self-employers, 26 U.S.C. §§ 1401 (b), 3101(b) and 3111(b) (1970), the Federal Hospital Insurance Trust Fund, § 1395i. The hospital services are paid for directly by the government. However, only those hospitals and other institutions that qualify as "providers of services" under § 1395x(u),[5] incorporating § 1395x(e), (j), and (*o*), and that are accredited under § 1395bb, are eligible to receive payments under the program, § 1395f(a). They can do so only after entering into agreements with the Secretary of HEW meeting the requirements of § 1395 cc(a), § 1395f(a). They must agree, among other things, not to charge a Medicare beneficiary for any services re-

[2] And miscellaneous other sections of Title 42 not pertinent here.

[3] Part B is the subject of a companion case, Szekely v. Florida Medical Association (Weinberger), also decided today, *see* — F.2d —, —. Part C, 42 U.S.C. §§ 1395x-1395pp (Supp. III), containing general provisions applicable to both Parts A and B, is at issue in both cases.

[4] All references to sections mean sections of Title 42 of the U.S. Code, 1970 edition, or any supplement thereto, unless indicated otherwise.

[5] The provision cited also refers to extended care facilities (changed to skilled nursing facilities by the 1972 amendments) and home health agencies.

ceived under the program, § 1395cc(a)(1)(A), other than for co-insurance and deductibles prvoided for in § 1395cc (a)(2)(A), but instead to look only to the government for compensation. Payment for services is based on the reasonable cost of such services, § 1395f(b), as determined pursuant to § 1395x(v) and the appropriate regulations, 20 C.F.R. § 405.401 *et seq.*

Day-by-day administration of the Medicare program is handled by "fiscal intermediaries." These are private, non-government entities, frequently health and accident insurance companies (including "Blue Cross" organizations) nominated by a provider or group of providers. They enter into contracts with HEW and serve as HEW's agent for many functions, such as hospital audits, information dissemination, and fund disbursement, § 1395h. Defendant Blue Cross of Florida, Inc., is the fiscal intermediary between Mount Sinai and HEW and also agent for HEW. Defendants Blue Cross and the Secretary of HEW will be referred to collectively as "HEW."

Providing services to a beneficiary raises two important and distinct issues: (1) whether the services provided are covered by § 1395d and not excluded by § 1395y; and (2) whether the amount paid for the services is the "reasonable cost" under § 1395x(v).[6] Each issue is resolved under distinct procedures. In resolving the question before us we must consider the bearing of these separate procedures on a recoupment section that makes no distinction between cost questions and coverage questions.

A. *Coverage determinations*

The issues in coverage determinations are defined by §§ 1395d and 1395y. Section 1395d defines the benefits covered by Medicare: in-patient hospital services, post-

[6] A third question, eligibility of the beneficiary under §§ 1395c and 1395d, is procedurally indistinguishable from the coverage determinations under §§ 1395y and 1395d, 1395ff(b)(1)(C).

hospital extended care services and post-hospital home health services with annual day or visit limits for each, § 1395d(a)(1)-(3). Section 1395y defines exclusions from the general definition of scope of benefits in § 1395d. The most important as a practical matter are the exclusions from coverage of services "which are not reasonable and necessary for the diagnosis or treatment of illness or injury . . . ," § 1395y(a)(1), or which are for "custodial care," § 1395y(a)(9). The instant case involves services found by HEW not to be covered because not medically necessary under § 1395y(a)(1).

The parties primarily concerned with coverage determinations are HEW and the beneficiary. In theory the provider's interest is slight because the coverage determination merely has the effect of resolving who shall pay it for the services, Medicare or the individual. The administrative procedures for making the coverage determination reflect these theoretical interests, for only the beneficiary has a right to hearing and judicial review under the statute, §§ 1395ff(b)(1)(C) and (b)(2), and the regulations, 20 C.F.R. §§ 405.701 *et seq.*, see particularly §§ 405.702, -.710, -.720, -.730 and -.750.[7] As a practical matter, however, the provider is greatly concerned about who its debtor is. The alternative debtors are the government and a private individual who may be hard to find, harder to collect from, and impossible to placate if collection from him is necessary.

B. *Cost determinations*

The issues in cost determinations are defined by § 1395x (v) and the regulations pursuant thereto, 20 C.F.R. § 405.-401 *et seq.* The rules for what constitutes reasonable cost have a substantial impact on when and how the reasonable cost determinations can be made. The general rule is that

[7] The 1972 amendments give the provided standing and a right to judicial review in coverage determinations. *See* footnote 22, *infra*.

Medicare will cover all costs of covered individuals, and no costs of individuals not covered, 20 C.F.R. §§ 405.454(a)(1) and (b)(1). The costs of a hospital department or service allocable to Medicare beneficiaries is based on the proportion of charges made with respect to Medicare beneficiaries to all charges for hospital services, 20 C.F.R. §§ 405.452 (a), (b) and (e)(1). This computation of the proportion of charges can be made only at the end of some fiscal period. Thus, the final determination of the reasonable costs for any given service can be finally determined only at the end of the fiscal year during which the service was supplied. HEW is required to make periodic interim payments in the meantime, not less frequently than monthly, § 1395g, to meet hospitals' liquidity needs, 20 C.F.R. § 405.402(b)(1). These payments are approximations of what HEW and the hospital expect will be properly chargeable to Medicare. The fiscal intermediary audits the accounts of each hospital on an annual basis to determine how much the hospital should have been paid. Subsequent payments for the following year's services are adjusted to compensate for prior payments that were above or below the amounts actually owed, § 1395g and 20 C.F.R. §§ 405.-451(b)(1) and 405.454(a) and (f).

Section 1395g is limited in its impact to cost redeterminations and does not touch coverage problems. Despite its general references to "overpayments," similar to § 1395gg (b), consideration of the Medicare Act as a whole shows that this section has much more limited scope than is contended for by the government. The District Court's opinion on this question correctly analyzes the statutory scheme. 376 F.Supp. at 1127-1129. Congress chose to pay providers only the "reasonable cost" of services, to be determined at the end of each fiscal year. Lump sum annual payments made long after services were rendered would be inadequate in light of hospitals' liquidity needs, so Congress authorized interim estimated payments to providers to be paid at least monthly with subsequent adjustments for overpayments and underpayments. Thus, some adjustment for overpayments and underpayments was necessitated by the "reasonable cost" payment system provided in §§ 1395f(b) and 1395x(v), and specifically by the proviso for "suitable corrective retroactive adjustments." § 1395x(v)(1)(A)(ii). This is exactly the function of the adjustments authorized in § 1395g. The contents of §§ 1395g and 1395x(v)(1)(A)(ii) track each other so closely that there would seem to be no other conclusion than that Congress intended that § 1395g relate only to cost determinations.

The parties primarily concerned with cost determinations are HEW and the provider. The beneficiary has no interest in them because the provider has already agreed to look only to HEW for compensation for services provided, § 1395cc (a)(1)(A).[8] The statute does not provide for any type of administrative hearing or judicial review for the provider itself, § 1395g, *cf.*, § 1395ff. And at the time the dispute leading to the litigation occurred no regulation provided any right to hearing or review. The regulation utilized by HEW and relied on by HEW in this litigation was promulgated pursuant to § 1395g. It authorizes HEW to suspend payments to a provider in whole or part when HEW determines that the provider has been overpaid, 20 C.F.R. § 405.370(a)(1), or has reliable information to that effect, 20 C.F.R. § 405.370(a)(2). This section provides for no "hearing" properly so called beyond a right to a statement from HEW of the reasons for the suspension and a privilege to submit information to show that the suspension should not be put into effect, 20 C.F.R. § 405.371(a), or would cause irreparable harm, 20 C.F.R. § 405.373(a). At least one district court has held the provider has a constitu-

[8] The beneficiary cannot be held liable where a provider has been paid more than its reasonable cost for services rendered to the beneficiary because the beneficiary cannot be at fault for the results of a proceeding in which he played no part, direct or otherwise, § 1395gg(c). *See* Part III. A, *infra*.

tional right to a hearing and judicial review on adverse reasonable cost determinations. *Coral Gables Convalescent Home, Inc.* v. *Richardson*, 340 F.Supp. 646 (S.D.Fla., 1972). HEW has issued regulations for such cost redetermination hearings, 20 C.F.R. §§ 405.490–405.499i (1973), now § 405.1801 *et seq.*

C. The adjustment and recoupment provision

The final element in the statutory scheme is § 1395gg, which authorizes HEW to recoup some overpayments from beneficiaries' old-age benefits, but only where "the excess over the correct amount cannot be recouped from [the] provider." The section does not by itself authorize recoupment from providers, but it establishes the failure to recoup from providers as a precondition to recoupment from beneficiaries, which it does explicitly authorize.[9] It thus assumes that there is some kind of right in HEW to recoup overpayments from providers, but it gives little hint as to the basis or scope of this right. It is not seriously disputed that this reference to recoupment means the common law recoupment for which the government contends in this case. But the question to be resolved is whether the scope of this common law right has been affected by the pervasive and complex statutory scheme present in the Medicare hospital insurance system.

II. The Government's Common Law Right to Recoup

The trial court held that the government's common law right to recoup would be available but for the statute present in this case. 376 F.Supp. at 1126. We agree. In

[9] Congress added a second precondition in the 1972 amendments to the Medicare Act: the provider must also be "without fault" before HEW can proceed against the beneficiary, §1395*gg* (b)(1)(B). In effect, this means that recoupment cannot be had from the provider where it was without fault. This was Congress' intent. *See* footnote 26, *infra*.

some circumstances when government funds are improperly paid out the government has a claim enforceable either by direct suit [10] or by setoff against money owed by the government to the recipient of the illegally dispensed funds.[11] The difficult question is what kinds of illegal or improper disbursements create this cause of action. Where the relevant statute did not authorize such payment, *United States* v. *Wurts*, *supra*, footnote 10, *Hilburn* v. *Butz*, *supra*, footnote 11, or specifically prohibited it, *United States* v. *Barlow*, *supra*, footnote 10, the United States has a cause of action to recover the money thus erroneously paid, and "no statute is necessary to authorize the United States to sue in such a case," *United States* v. *Bank of Metropolis*, 40 U.S. at 401, 10 L.Ed. at 783. Similarly, where the payments would be authorized but for erroneous understandings of fact, the government may recover, even where its own employees and agents were partly responsible for failing to discover the correct facts, *United States* v. *Barlow*, *supra*, footnote 10, but not where they were guilty of a "mere error of judgment," 132 U.S. at 280, 10 S.Ct. at 79, 33 L.Ed. at 351.[12]

Here, the statute specifically prohibits any payments for services that are medically unnecessary, § 1395(a)(1). This

[10] United States v. Wurts, 303 U.S. 414, 415, 58 S.Ct. 637, 638, 82 L.Ed. 932, 934 (1938); United States v. Barlow, 132 U.S. 271, 279-280, 281-282, 10 S.Ct. 77, 79-80, 33 L.Ed. 346, 351-352 (1889); Weiss v. United States, 296 F.2d 648 (CA 5, 1961).

[11] United States v. Munsey Trust Co., 332 U.S. 234, 67 S.Ct. 1599, 91 L.Ed. 2022 (1947); Hilburn v. Butz, 463 F.2d 1207 (CA 5, 1972); *see also* United States v. Bank of Metropolis, 40 U.S. (15 Pet.) 377, 400-401, 10 L.Ed. 774, 783 (1841), in which defendant in an assumpsit action by the United States was denied a setoff where the claimed credit on which it was based was not authorized.

[12] Although the Court there makes reference to a statute authorizing suit, quoted in 132 U.S. at 277, 10 S.Ct. at 79, 33 L.Ed. at 350, the distinction drawn between errors of judgment and mistakes of fact is not derived from the words of the statute.

prohibition is part of the statute creating the administrative system under which all payments are authorized; it implicitly limits the authority of HEW officials to make payments under Medicare. This is exactly the kind of limitation which under federal common law creates both a legal claim in the government and a remedy by way of set-off, as was attempted to be exercised by HEW in this instance.[13] Moreover, the government has asserted that its agents did not exercise their judgment on the precise question of medical necessity but acted on erroneous understandings of the facts presented to them in the certificates executed by the provider and doctors under § 1395f(a) and § 1395f(a)(3) in particular. See *United States* v. *Barlow*, *supra*, footnote 10, and compare *Dana Corp.* v. *United States*, 470 F.2d 1032 (Ct.Cl., 1972).

In finding the government's common law recoupment right applicable but for the statutory scheme present here the trial court drew no distinction between gratuitous payments made to beneficiaries and payments to contractors or others where some legal consideration might have passed. This is in accord with the case law. The issue is not the nature of the relationship or the position of the recipient but whether the money was illegally or erroneously paid. The government has previously prevailed in recouping funds paid to government contractors and others who were not gratuitous beneficiaries. *United States* v. *Bank of Metropolis*, *supra*, footnote 11. *Wilson Clinic & Hosp., Inc.* v. *Blue Cross of So. Carolina*, 494 F.2d 50, 52 (CA4, 1974); *United States* v. *Mead*, 426 F.2d 118, 124 (CA9, 1970); *Dana Corp.* v. *United States*, *supra*; *Cf.*, *Weiss* v. *United States* *supra*, footnote 10, *Hilburn* v. *Butz*, *supra*, footnote 11

Moreover Mount Sinai is not a neutral, innocent third party in this three-way transaction between HEW, Medi-

[13] *Cf.* United States v. Associated Transport, 505 F.2d 366 (CA DC, 1974).

care beneficiary, and Medicare provider. The decision to provide a service is made by the individual attending physician, who is far better informed on both the medical issue and the scope of Medicare coverage than is the patient-beneficiary. The physician is either an employee of the hospital or a doctor with staff privileges. Whatever else the granting of staff privileges may connote, it is clear to us that it involves a delegation by the hospital of authority to make decisions on utilization of its facilities. Certainly in the case of Mount Sinai, where the majority of patients and patient-days are under Medicare insurance, this must also include a delegation of authority to permit the use of its facilities for Medicare-financed patients.

It is suggested by Mount Sinai that recoupment should not apply where it has not received a "windfall." The hospital did not receive money without giving something in return. No one questions that services were provided at reasonable cost for all the payments actually received. But the unfairness in not paying for services that were provided has nothing to do with recoupment. Indeed, this provision of services without payment by Medicare is exactly what happens no matter when HEW decides a service is not covered. Mount Sinai does not challenge the authority of the government to make its decision not to pay for a service after the performance of the service. The only distinctions between not making payment in response to an original claim, which Mount Sinai concedes is proper, and seeking to recoup payment after it has been made, which the hosptial challenges, are the making of the preliminary decision to pay and the subsequent passage of time. Whether payment is denied or payment is made and recoupment asserted, the hospital has already provided the services and suffers the same loss of compensation from the Medicare program for services rendered. In both situations, it must then turn to the patient for payment. The delay incident to the use of recoupment

may cause greater difficultly in proving that the services given were medically necessary and in collecting from the patient. But we do not consider these factors to have any bearing on the government's right to recoup.

III. Effect of the Statute on the Right to Recoup

The trial court held that the right to recoup was abrogated in this case by the comprehensive "all-encompassing" administrative system embodied in the Medicare Act and its amendments, 376 F.Sup. at 1127. The court found congressional intent to abrogate "manifested by the totality of the statutory scheme," *id.*, at 1130. We think that Congress' intent when it enacted the Medicare Act in 1965 was not to limit the common law right. Provisions not referred to by the trial court [14] show that Congress' understanding in 1972 when it amended the law was that the common law right was intact and was expected to be utilized. The recoupment right does not always fit consistently and logically into the statutory system, but the alternative of no right to recoup produces even more severe incongruities. Provisions aparently contrary to the government's right to recoup serve important functions that complement rather than displace or supersede the recoupment right. Where a difficult but not dispositive conflict appears between statute and common law, Congress has already acted in the 1972 amendments to reconcile the statute to the recoupment right.

A. Congressional intent—the original act

Section 1395gg justifies recovery of overpayments paid to providers from the beneficiaries who received the services paid for by saying that any payment to a provider "shall be regarded as a payment to" the beneficiary who

[14] And presumably not called to its attention since not cited to us by either of the parties until post oral argument memoranda were filed at our request.

received the services for which the payment was made, § 1395gg(a). It then authorizes HEW to deduct the amount owed from the beneficiary's old-age benefits under Title II of the Social Security Act, *but only when "the excess over the correct amount cannot be recouped from [the] provider . . .,"* § 1395gg(b)(1) (emphasis added).[15] On its face, this reference to recoupment from providers would appear to be dispositive. It shows that Congress expected and intended HEW to recoup improper payments to providers without limitation as to the reason for the overpayment, and authorized deductions from beneficiaries' old-age benefits only as a last resort after recoupment had failed. However, we must go deeper than the face of the provision.

The alternative remedies of recoupment and adjustment posit an area of comon liability where both provider and beneficiary are alternatively responsible to the trust fund for the same overpayment. Providers can be held liable for reasonable cost overpayments, and beneficiaries can be held liable for coverage overpayments. But to have common liability either providers must be subject to liability for coverage overpayments or beneficiaries must be subject to liability for reasonable cost overpayments.[16]

Elsewhere the act sets up different procedures for determinations respecting cost and those respecting coverage. Providers take no part in coverage hearings and beneficiaries have nothing to do with cost determinations. Mount Sinai puts great emphasis on this procedural system and suggests that it is out of keeping with this bifurcated

[15] This language now apepars as § 1395gg(b)(1)(A). A 1972 amendment added a second precondition to deduction from a beneficiary's old-age benefits: the provider must also be without fault for the overpayment, § 1395gg(b)(1)(B). *See* footnote 26, *infra*.

[16] Or both could be liable for coverage overpayments and both liable for cost overpayments. For reasons appearing below, we think not.

scheme to subject it to recoupment of funds overpaid with respect to coverage. This argument has little force because the common liability posited by the section must exist inconsistently with the procedural structure either for providers or for beneficiaries or for both, and the same argument made by Mount Sinai is available to a beneficiary.

A difficulty with subjecting providers to liability for non-covered services is that the provider then has an action over against the beneficiary under state law. As between HEW and the beneficiary, HEW could not collect directly from the beneficiary because it has already made a determination of coverage under § 1395ff(b) to which HEW and the beneficiary were the only parties. Thus the beneficiary may become liable to the provider for the services received, even though in the only prior contact with the Medicare program, the coverage determination under § 1395ff(b), the decision made was that Medicare would pay for the service and the patient was not liable.[17] [18]

[17] This anomaly is rendered more severe because of the differing parties in the various determination procedures and the different procedural rights given each. The beneficiary has a statutory right to a hearing and, where the dispute rises above certain dollar minimums, a statutory right to judicial review, § 1395f(b)(2). These rights are elaborated on in HEW regulations, 20 C.F.R. § 405.701 *et seq.* But the provider, against whom HEW may proceed after its rights against the beneficiary have long lapsed, has no such protections. The hearings which the provider receives consists of a right to submit evidence on the issues of propriety of suspension and irreparable harm and the right to be apprised of the reasons for the suspension. See Part I. B, *supra*. Thus the administrative system's different procedures increase the probability of inconsistent results between different parties.

[18] Mount Sinai also suggests that subjecting it to coverage recoupment is unfair because of the limitation of § 3995ee(a)(1)(A) that providers agree not to charge beneficiaries for any covered services. This provision merely requires the provider to choose between charging the Medicare trust fund or charging the beneficiary for the service provided, depending on whether the service was covered or not. It does not prohibit the provider from charging the beneficiary for a non-covered service nor does it expose the provider to the sanctions of § 1395ee(b)(2)(A) for charging beneficiaries for covered services, so long as the provided thought the service was not covered and did not attempt to collect from Medicare for it. Mount Sinai may be concerned about the prospect of doctors deciding in favor of coverage only to be contradicted by the hospital's review or claims unit. The Act does not distinguish between doctors and providers in that way; they are viewed as a single entity. Once they have resolved their differences they can act, and they can charge whoever should be liable, Medicare if the service was covered, the beneficiary if it was not covered.

A difficulty with subjecting beneficiaries to liability for payments in excess of reasonable cost is that the beneficiary is truly an innocent third party. He not only did not take part in the original reasonable cost determination, but he can neither gain nor lose by the outcome and can have no responsibility for erors. No matter what the outcome of this determination, the beneficiary can suffer no additional liability. He has no knowledge of the determination and no real interest in the matter. Thus, the failure of Congress to have beneficiaries take part in reasonable cost determinations reflects beneficiaries' bona fide interests. In light of the unfairness in subjecting beneficiaries to this liability we do not think Congress intended such a result.[19]

To explain the common liability posited by § 1395gg while excluding provider liability for coverage overpayments, Mount Sinai contends that beneficiaries are subject

[19] By contrast, providers are not strangers to the coverage determination. It is the provider who makes a decision on coverage in the first instance and certifies to the medical necessity of the services provided. And who will be the provider's debtor liable for the services rendered will be determined in the coverage hearing. Thus, providers have both knowledge of and an interest in the hearing, and subjecting them to liability for coverage errors not only does not offend notions of fairness, but may be both fair and reasonable.

to liability for reasonable cost overpayments. This result it supposes is authorized by the basic premise of § 1395gg contained in § 1395gg(a), the subsection which says payments to providers are to be regarded as payments to the beneficiaries who received the services. Mount Sinai argues that Congress was simply recognizing beneficiaries as the ultimate recipients of the funds and placing on them the ultimate responsibility for incorrect payments.

We think Congress had something else in mind in enacting § 1395gg, and § 1395gg(a) in particular. No recovery against the individual beneficiary—who received only medical services, not payments from the trust fund—would ever be proper without some statutory authorization. That is the limited function of § 1395gg(a). Congress could not authorize reductions of old-age benefits without some reason, and the reason statutorily supplied is that Medicare payments are to be considered payments actually made to the beneficiary.

Thus, § 1395gg taken as a whole does not provide for primary responsibility of the beneficiary with narrow provider responsibility for payments in excess of reasonable cost. Rather, it posits general provider responsibility based on the fact that providers receive the funds, but permits a narrow category of recovery from beneficiaries, *i. e.*, when the provider is not available and the beneficiary was at fault for the erroneous payment.

Other parts of §1395gg suggest that Congress never intended beneficiaries to be held liable for administrative errors in cost determinations, errors which they had no part of, could not have contributed to if they wanted to, and in which they had no interest. Section 1395gg(c) prohibits recovery from the beneficiary by adjustment of old-age benefits where the beneficiary was without fault. A beneficiary cannot be at fault for erroneous cost determinations since he plays no role at all in the proceedings.

In light of this limitation of § 1395gg(c), we conclude that § 1395gg(b) was not intended to authorize recovery of overpayments based on erroneous reasonable cost determinations.

This leaves only responsibility for coverage errors as the common liability of provider and beneficiary. Thus coverage errors comprise the entire scope of operation of § 1395gg(b). The proviso in § 1395(b)(1)(A) requiring an attempt to recoup from the provider as a precondition to adjustment thus must contemplate provider liability for such overpayments.[20]

There is a possibility of inconsistent results in the different coverage determinations made between HEW and the beneficiary before payment and between HEW and the provider after payment, but this possibility is consonant with both the Medicare Act and general recoupment law. Standing alone, it does not show that Congress intended abrogation of recoupment. Congress was parsimonious in granting rights to providers in the original act. For example, where the provider's claim to a right to a hearing and judicial review was stronger—following adverse reasonable cost determinations under § 1395ff(b)(1)—Congress was silent and gave no statutory hearing or review.[21] Moreover, as to intent, Congress' response on learning of this difficulty was not to eliminate recoupment but to give providers standing in the administrative determination of coverage questions and the right to judicial review, § 1395-

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[20] This is not to say that recoupment is limited to overpayments due to coverage errors, but merely that it must include coverage errors.

[21] A district court has held that there is a constitutional right to a hearing and judicial review from such adverse cost redeterminations. Coral Gables Convalescent Home, Inc. v. Richardson, 340 F.Supp. 646 (S.D.Fla., 1972).

pp, added in 1972.[22] Nor does the possibility of inconsistent results require a holding of abrogation of common law recoupment on the basis that it is incompatible with the statutory system. The ultimate result of inconsistent decisions is that the provider must bear the loss. The fact that but for the earlier proceeding the provider might have been able to recover over from a third party, the beneficiary puts the provider in no worse situation than other recipients of improperly disbursed government funds. See the discussion of the recoupment right generally, Part II, *supra*.

B. *Congressional intent—the 1972 amendments*

Nothing in the orginal act explicitly referred to recoupment from providers of payments made for non-covered services. The 1972 amendments filled the gap. Four related amendments refine the defenses to recoupment for both beneficiary and provider and esablish that recoupment

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[22] The principal function of the new section is to authorize payments where neither provider nor beneficiary knew or should have known that a service was not medically necessary, § 1395pp(a), a modification of the exclusion in § 1395y(a)(1). The hearings for providers as well as beneficiaries is provided for in § 1395pp(d). Although not specified in terms, the most reasonable construction would be that where § 1495pp(a) authorizes payment (*i.e.*, the provider should not have known that the service was medically unnecessary), then § 1395gg(b) does not authorize recoupment (the provided was "without fault"). Conversely, where § 1395pp (a) does not authorize payment (*i.e.*, the provider should have known the service was medically unnecessary), then § 1395gg(b) does authorize recoupment (the provider was not "without fault"). Thus, authorization and recoupment interlock neatly and the hearing on authorization deals with the issues involved in recoupment. The § 1395pp(d) hearing may be held whenever authorization of payments is questioned, and that may occur either before or after payment, *viz.*, in a recoupment proceeding.

from the provider for payments for non-covered services is assumed.[23]

In reporting these amendments, the Senate Finance Committee told Congress:

> Under present law, the Secretary [of HEW] is required to recover overpayments made to or on behalf of an individual where it is determined that [the] services. . . were not covered under [M]edicare. Further, present law provides that overpayments made to providers or other persons for services furnished . . . which cannot be recovered from the overpaid provider[24] . . . may be recovered [by adjustment of the individual beneficiary's old-age benefits].

S.Rept. 92-1230, 92d Cong., 2d Sess., pp. 313-314 (1972).

The Senate committee assumed that providers could be held liable for payments for non-covered services. Acting on that assumption, it proceeded to recommend (and Congress subsequently enacted) refinements in §§ 1395gg(b) and (c). The refinement to HEW's right to make adjustments to a beneficiary's old-age benefits to recover overpayments is in effect a three-year statute of limitation.[25] The

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[23] The amendments are all contained in § 281 of the Social Security Amendments of 1972, Act of Oct. 30, 1972, P.L. 92-603, 86 Stat. 1454. Three of the amendments are discussed here. The fourth concerns Part B and is discussed in *Szekely, supra*.

[24] Strict reliance on the punctuation in the original Senate report of the phrase beginning "which cannot . . ." may lead to an interpretation contrary to that suggested by a reading of this portion of the legislative history as a whole. The ease with which errors of pnctuation can be made and overlooked makes us feel far more comfortable following the sense of the legislative history generally.

[25] Prior to 1972, adjustment of a beneficiary's old-age benefits to recover improper Medicare payments was permitted where the beneficiary was at fault and where such recovery by adjustment

refinement to HEW's right to recoup from providers makes non-fault a defense and sets up a presumption of non-fault three years after payment is made.[26]

Congress saw another problem: a provider required to make repayments might still attempt to collect from the beneficiary even though HEW itself was barred from doing so by the amendment to § 1395gg(c). The Senate report said:

> The amendment also requires that providers under their participation agreements (or physicians or other

was "not against equity and good conscience," § 1395gg(c). The 1972 amendment established the rule that adjustment was against equity and good conscience if the redetermination that services were not covered is made more than three years after payment, § 1395gg(c) [last sentence].

[26] Prior to 1972 it was not a valid defense to recoupment that a provider was not at fault for the overpayment. The amendment made absence of fault a defense, § 1395gg(b)(1)(B), and added the rebuttable presumption that the provider was not at fault where the redetermination was made more than three years after the original payment, § 1395gg(b) [last sentence].

Read narrowly, this change only says that a finding of the provider's non-fault is a precondition to adjustment of the beneficiary's old-age benefits to recoup the erroneous payment. Thus, it means that where the provider was at fault such adjustment is not permitted; where the provider was not at fault, adjustment is authorized. But adjustment is not required and recoupment is not prohibited. Conceivably, HEW might still have recoupment against the provider available as an alternate remedy. In light of the other restrictions on these old-age benefit adjustments, *e.g.*, § 1395gg(c), such an alternative would be reasonable. But the legislative history suggests otherwise. Congress added § 1395gg(b)(1)(B) to give providers protection similar to that for beneficiaries in § 1395gg(c) that "recovery . . . will not be made with respect to an individual who is without fault . . ." S.Rep. 92-1230, 92d Cong., 2d Sess., p. 314. Congress also added the last sentence to § 1395gg(b) giving providers presumption of non-fault after three years, analogous (but not identical) to the last sentence added to § 1395gg(c) giving beneficiaries an irrebutable rule of immunity.

> persons where they have accepted assignments) where collection of an overpayment is made from the provider or others, be prohibited, after 3 years, from charging beneficiaries for services found by the Secretary to be medically unnecessary or custodial in nature, in the absence of fault on the part of the individual who received the services.

S.Rept. 92-1230, 92d Cong., 2d Sess., p. 314 (1972). This amendment appears as § 1395cc(a)(1)(B).[27] By reason of this amendment providers are prohibited from charging patients for services not covered by Medicare where the determination of non-coverage is made more than three years after the original payment. This kind of protection would not be necessary unless (1) providers could be required to reimburse HEW for money received in payment for non-covered services, and (2) the determination of non-coverage could be made after the original determination under §§ 1395ff(a) and (b), indeed, more than three years after that determination.

Subsequent statements of Congress about what it meant years earlier in enacting a law are "entitled to great weight in statutory construction." *Red Lion Broadcasting* v. *F.C.C.*, 395 U.S. 367, 380-381, 89 S.Ct. 1794, 1801, 23 L.Ed.2d 371, 383 (1969). Here we have Congress at its most authoritative, adding complex and sophisticated amendments to an already complex and sophisticated act. Congress is not merely expressing an opinion on a matter which may come before a court but is acting on what it understands its own prior acts to mean. See *Red Lion, supra*, and cases cited in footnote 8, 395 U.S. at 380, 89 S.Ct. at 1801, 23 L.Ed.2d at 383. Moreover, certain of these new provisions explicitly refer to provider liability, whose existence is the question here litigated. To hold that HEW does not have the re-

[27] And § 1395u(b)(3)(B)(ii), with regard to physicians taking assignments under Part B. *See Szekely, supra.*

coupment power attempted to be exercised against Mount Sinai and giving rise to this case would render these amendments pointless and ineffectual.

The situation before is unlike those where Congress has attempted to direct subsequent court decisions on legislation whose original meaning was ambiguous, such as a Committee of Congress attempting to advise the courts of what it thought a prior Congress meant, *Bobsee Corp.* v. *United States,* 411 F.2d 231, 237, footnote 18 (CA.5, 1969); or Congress attempting to enact a clarifying amendment only to be rebuffed by the President who signed the original and thinks it has a different meaning, *Waterman S.S. Corp.* v. *United States,* 381 U.S. 252, 268-269, 85 S.Ct. 1389, 1398-1399, 14 L.Ed.2d 370, 379-380 (1963); of Congress failing to enact a clarifying amendment, from which ambiguous failure to act we are asked to draw some meaning, *United States* v. *Price,* 361 U.S. 304, 311-312, 80 S.Ct. 326, 330-331, 4 L.Ed.2d 334, 339-340 (1960); or legislative history vaguely referring to the prior state of the law, *United States* v. *Price,* 361 U.S. at 312-313, 80 S.Ct. at 331-332, 4 L.Ed.2d at 340.

Under these circumstances and in light of the construction we put on § 1395gg(b) as it existed prior to amendment, we think it clear that recoupment has always been available to HEW under facts like those of the instant case.

In an attempt to explain away these amendments particularly § 1395cc(a)(1)(B), Mount Sinai insists that they are merely refinements or limitations on a new liability, purportedly contained in § 1320c-9(b)(3), rather than on the pre-existing recoupment right. This argument verges on the frivolous. Section 1320c-9(b)(3) is part of the new system of professional standards review organizations (PSRO). The PSRO system was adopted to deal with "abuse" of the Medicare system by providers and physi-

cians.[28] The fine in § 1320c-9(b)(3) is merely an alternative sanction to total exclusion from the Medicare program, § 1320c-9(b)(1). To read this fine as the recoupment referred to in §§ 1395cc(a)(1)(B) and 1395gg(b) and (c) would produce gaping incongruities. The fine is levied only against Medicare abusers who "demonstrated an unwillingness or a lack of ability substantially to comply with" the obligation not to provide unnecessary or harmful services under § 1320-9(a)(1). Both of these grounds clearly envision some kind of fault. Yet § 1395gg(b)(1)(B) makes absence of fault a defense to recoupment. Moreover, to read this fine as the recoupment contemplated and limited by § 1395cc(a)(1)(B) suggests that providers could pass on to their patients this fine, levied only in lieu of expulsion from the Medicare program, if relevant determinations that

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[28] A related provision prohibits any Medicare payments to a provider or physician excluded after hearing from taking part in Medicare, § 1395y(d). The parties rely on the legislative history of this provision to illustrate what Congress intended with § 1320c-9(b)(3). This section and its history distinguish, as does § 1320c-9(b)(3), between mere rendering of an unnecessary service and "abuse"—"overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment." *See* S.Rept. 92-1230, 92d Cong., 2d Sess., p. 200 (1972); H.Rept. 92-231, 92d Cong., 1st Sess. pp. 98-99 (1971), U.S.Code Cong. & Admin. News 1972, p. 4989. *See also* the testimony of Social Security Administrator Robert H. Ball in House Ways and Means Committee *Hearings on the President's Proposals for Welfare and Social Security Amendments,* 91st Cong., 2d Sess., p. 154 (1970).

The lack of authority referred to in the committee reports, *e.g.,* S.Rept No. 92-1230 at p. 200, and by Commissioner Ball, was the lack of authority to withhold all future payments from particular providers who abused the program or endangered the lives of beneficiaries, that is, withholding amounting to total exclusion from the Medicare program. That is the authority HEW lacked prior to 1972 and that is the authority granted by Congress in §§ 1320c-9(b)(1) and 1395y(d). These references to a lack of authority to withhold future payments from such providers did not mean HEW could not withhold payments to offset any provider's liability to the program for prior erroneous overpayments.

services were not covered were made within three years of payment. This cannot be correct. The fine provided in § 1320c-9(b)(3) is a new liability, but it has nothing to do with the various limitations on liabilities in §§ 1395cc(a)(1)(B) and 1395gg(b) and (c), which were directed to the pre-existing right to recoup.

C. *Other provisions and recoupment*

1. Section 1395 provides, in part:

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . .

The argument is made that subjecting hospitals to liability in recoupment for fees paid for unnecessary medical services would constitute interference with and supervision of the practice of medicine in violation of this section. Mount Sinai states that if HEW has the unlimited right to recoup contended for here that hospitals will of necessity "be constantly forced to second-guess the physicians on a virtually daily basis," that the "omnious ever presence of a wholesale recoupment power would create such a chilling effect . . . as to materially affect the ability and inclination of providers to act solely on the basis of the honest medical judgment of physicians" resulting, as a practical matter, in "interference with the practice of medicine."

Elsewhere the act provides for an immediate claims review system, § 1395f(a)(1). A doctor or other provider of medical services decides whether the service is covered, and it either pays or does not pay, as it decides, §§ 1395f(a)(1), 1395ff(a) and 20 C.F.R. § 405.701 *et seq.* Thus HEW must decide in every case whether to pay for the services. The immediate review system was enacted by the same Congress that enacted § 1395. It is not seriously contended that the statutorily-mandated system for immediate review constitutes the kind of interference with and supervision of medical care prohibited by § 1395. Post-payment recoupment is not shown to be more onerous than the immediate review system. We conclude that recoupment is not proscribed by § 1395.

2. There are features of the original Medicare Act which relate to recovering improperly disbursed funds, but none does so in such a way as to suggest that Congress had considered the matter and decided not to utilize the common law recoupment right. Thus, § 1395y(b) requires that all payments under Medicare be conditioned on reimbursement when the services have been paid for by a workmen's compensation plan. By contrast, the exclusions in § 1395y(a), *e.g.*, for medically unnecessary services and custodial care, are absolute. Payment is never permitted and there is no reference to subsequent reimbursment.

The difference has no implications for recoupment. The purpose of provisional payment is to leave the account open to allow for subsequent contingent events which bear on liability. Congress could easily perceive that whether a certain medical service would be paid for under a workmen's compensation act would be unknown and perhaps could not even be reasonably surmised at the time the Medicare claim was made. It thus authorized provisional payment but then also authorized recovery if workmen's compensation did pay. The § 1395y(a) excluusions, by contrast, are not amenable to provisional payment. Whether certain treatment reasonably appears to be medically necessary at the time of the provider's decision does not depend on later contingencies. Nor did Congress want to shift liability to beneficiaries because reasonable judgments of medical necessity prove ultimately to be erroneous.[29] There was thus no reason to authorize provisional payments and their recovery.

---

[29] Of course, it may turn out that a certain treatment was not necessary because based on an erroneous diagnosis or for some other reason, but the proper test must be the reasonableness of the diagnosis and treatment at the time the diagnosis was made and the treatment decided upon.

In a like vein, the specific authority for after-the-fact adjustments for payments subsequently found to be erroneous under HEW's reasonable cost regulations does not suggest that other after-the-fact repayments or adjustments were not contemplated. The section authorizing such adjustments also authorizes interim estimated payments not less frequently than monthly, § 1395g. As the trial court noted, the authorization for adjustments for overpayments "simply recognizes and reconciles the conflicting demands of Section 1815 [§ 1395g] for periodic settlement of the reasonable cost due when the necessary data becomes available, yet for sufficient frequency of payment to generate an adequate cash flow for the provider." 376 F.Supp. at 1129.

To summarize, we hold that the government's common law right to recoup is available to HEW in its implementation of the Medicare hospital insurance program to recover from providers funds for medically unnecessary services.[30] The other questions posed by the parties' briefs to this court we leave to the District Court on remand.[31] We remand for further proceedings not inconsistent with this opinion

Reversed and remanded.

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[30] The result may be harsh at times. Congress has chosen to deal with that harshness by its 1972 amendments, in particular the amendments of §§ 1395gg(b) and (c).

[31] *See* footnote 1, *supra*.

APPENDIX

Court of Appeals Opinion on Rehearing

UNITED STATES COURT OF APPEALS,
FIFTH CIRCUIT.

No. 74-2154.

MOUNT SINAI HOSPITAL OF GREATER MIAMI, INC.,
Plaintiff-Appellee,

v.

CASPAR WEINBERGER, Secretary of Health, Education and Welfare, and Blue Cross of Florida, Inc., *Defendants-Appellants.*

* * *

Appeal from the United States District Court
for the Southern District of Florida.

On Petition for Rehearing and Petition for Rehearing En Banc

(Opinion 8-8, 1975, 5 Cir., 1975, 517 F.2d 329).

Before BROWN, Chief Judge, and GODBOLD and CLARK, Circuit Judges.

PER CURIAM:

The petition for rehearing and for rehearing en banc correctly points out that our original opinion was not consistent in its references to whether the beneficiary would be liable to a provider hospital if HEW made a determination that the services were not covered and then recouped from the provider. Our view is that the provider may turn to the patient as a possible source of payment. Whether the hospital, if it cannot get voluntary payment, may successfully sue the beneficiary will depend upon the extent to which the statutory scheme permits the provider to enter into a contract with the beneficiary by which the beneficiary undertakes that responsibility, and also upon the terms of any contractual arrangement actually made. We do not, and need not, decide on this appeal the interplay of statute and right to contract. The exposure of the

provider to the possibility of bearing the loss does not require us to hold that the Act does not permit inconsistent determinations of coverage or to hold that there can be only a single determination of coverage which binds everyone whether he is a party to it or not.[1] And, as we explained in the original opinion, Congress has to some degree ameliorated providers' exposure by giving them standing in the administrative determination of coverage questions and the right to judicial review. See footnote 22 and accompanying text.

Except to the extent that by this opinion we have modified our original opinion, the petition for rehearing is denied and no member of this panel nor Judge in regular active service on the court having requested that the court be polled on rehearing en banc (Rule 35 Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12) the petition for rehearing en banc is denied.

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[1] The beneficiary also labors under the threat of inconsistent determinations. Despite the fact that he receives services pursuant to a coverage determination, it may be later and inconsistently determined that there was an overpayment, and HEW may choose to collect by offsetting his Title II benefits. The second determination is made in a new proceeding, not a reopening or reconsideration of the original determinuation, § 1395gg(b) and (c) and 20 C.F.R. § 404.901 *et seq.*

APPENDIX

Constitutional and Statutory Provisions

CONSTITUTIONAL AND STATUTORY PROVISIONS

The Fifth Amendment to The Constitution of the United States provides, in pertinent part, as follows:

> No person shall be . . . deprived of life, liberty, or property, without due process of law . . .

The Health Insurance for the Aged Act ("The Medicare Act"), Pub. L. 89-97, §§ 100 *et seq.* (July 30, 1965), 79 Stat. 291, 42 U.S.C. 1395, as originally enacted provided in pertinent part:

> 42 U.S.C. 1395(a)(7) and (b):
>
> Except as provided in subsection (d) of this section, payment for services furnished an individual may be made only to providers of services which are eligible therefore under section 1395cc of this title and only if—
>
> • • •
>
> (7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1395x(k)(4) of this title) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or extended care facility, as the case may be, received notice of such finding.
>
> • • •
>
> (b) Reasonable cost of services.
>
> The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section

42 U.S.C. 1395(b)(cont.):

1395e of this title, be the reasonable cost of such services, as determined under section 1395x(v) of this title.

42 U.S.C. 1395y(a)(1):

Exclusions from coverage.

(a) Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses incurred for items or services —

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a maliformed body member:

42 U.S.C. 1395ff:

Determinations; appeals.

(a) The determination of whether an individual is entitled to benefits under part A or part B and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Any individual with any determination under subsection (a) of this section as to entitlements under part A or part B, or as to amount of benefits under part A where the matter in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a

42 U.S.C. 1395ff (cont.):

hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

42 U.S.C. 1395gg(a)-(c):

Overpayments on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals.

(a) Any payment under this subchapter to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Where—

(1) more than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or

(2) any payment has been made under section 1395f (e) of this title to a provider of services or other person for items or services furnished an individual.

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1937, as the case may be, or

(4) If such individual dies before such adjustment has been completed, to which any other individual is

42 U.S.C. 1395gg(b) (cont.):

entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1937, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under subchapter II of this chapter.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1395i(g) of this title, and section 1395t(f) of this title, shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1937) the amount of the overpayment as to which the adjustment is to be made.

(c) There shall be no adjustment as provided in subsection (b) of this section (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1395f(e) of this title) with respect to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of subchapter II of this chapter or would be against equity and good conscience.

* * *

The following provisions were among those added to the Medicare Act by Pub. L. 92-603 (Oct. 30, 1972), 86 Stat. 1385:

42 U.S.C. 1395 pp:

Limitation on liability where claims are disallowed—Conditions prerequisite to payment for items and services notwithstanding determination of disallowance

(a) Where—

(1) a determination is made that, by reason of section 1395y(a)(1) or (9) of this title, payment may not be made under part A or part B of this subchapter for any

42 U.S.C. 1395pp (cont.):

expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1395u(b)(3)(B)(ii) of this title, and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B of this subchapter.

then to the extent permitted by this subchapter, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this subchapter), as though section 1395y(a)(1) of this title and section 1395a(9) of this title did not apply. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services.

(b) in any case in which the provisions of paragraphs (1) and (2) of subsection (a) of this section are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B of this subchapter, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred

42 U.S.C. 1395pp (cont.):

to in such paragraphs), subject to the deductible and coinsurance provisions of this subchapter, for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services.

(c) No payments shall be made under this subchapter in any cases in which the provisions of paragraph (1) of subsection (a) of this section are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B of this subchapter by reason of section 1395y(a)(1) or (a)(9) of this title.

(d) In any case arising under subsection (b) of this section (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c) of this section, the provider or other person shall have the same rights that an individual has under section 1395ff(b) of this title (when the determination is under part A) or section 1395(b)(3)(C) of this title (when the determination is under part B) when the amount of benefit or payments is in controversy that such rights may, under prescribed regulations, be exercised by such provider or

42 U.S.C. 1395pp (cont.):

other person only after the Secretary determines that the individual will not exercise such rights under such sections.

42 U.S.C. 1320c-9:

Obligations of health care practitioners and providers of health care services—Enumeration of obligations

(a)(1) It shall be the obligation of any health care practitioner and any other person (including a hospital or health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this chapter, to assure that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this chapter—

(A) will be provided only when, and to the extent, medically necessary; and

(B) will be of a quality which meets professionally recognized standards of health care; and

(C) will be supported by evidence of such medical necessity and quality in such form and fashion and at such time as may reasonably be required by the Professional Standards Review Organization in the exercise of its duties and responsibilities:

and it shall be the obligation of any health care practitioner in ordering, authorizing, directing, or arranging for the provision by any other person (including a hospital or other health care facility, organization, or agency), of health care services for any patient of such practitioner, to exercise his professional responsibility with a view to assuring (to the extent of his influence or control over such patient, such person, or the provision of such services) that such services or items will be provided—

(D) only when, and to the extent, medically necessary, and

(E) will be a quality which meets professionally recognized standards of health care.

42 U.S.C. 1320c-9 (cont.):

(2) Each health care practitioner, and each hospital or other provider of health care services, shall have an obligation, within reasonable limits of professional discretion, not to take any action, in the exercise of his profession (in the case of any health care practitioner), or in the conduct of its business (in the case of any hospital or other such provider), which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility unless—

(A) inpatient care is determined by such practitioner and by such hospital or other provider, consistent with professionally recognized health care standards, to be medically necessary for the proper care of such individual; and

(B)(i) the inpatient care required by such individual cannot, consistent with such standards, be provided more economically in a health care facility of a different type; or

(ii) (in the case of a patient who requires care which can, consistent with such standards, be provided more economically in a health care facility of a different type) there is, in the area in which such individual is located, no such facility or no such facility which is available to provide care to such individual at the time when care is needed by him.

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1320c-6 of this title (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems ap-

42 U.S.C. 1320c-9 (cont.):

propriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this chapter has—

(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a) of this section, or

(B) by grossly and flagrantly violating any such obligation in one or more instances,

demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis.

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in subchapter XVIII of this chapter with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or provider to provide such health care services on a reimbursable basis)

42 U.S.C. 1320c-9 (cont.):

such practitioner or provider pay to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or provider of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided, or (if less) $5,000. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed.

(4) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of his title.

(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Profesisonal Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a) of this section) providing health care services in such area shall comply with all obligations imposed on him under subsecion (a) of this section.

Supreme Court, U. S.
FILED
FEB 4 1976
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER, 1975

No. 75-1041

MT. SINAI HOSPITAL OF GREATER MIAMI, INC., *Petitioner*

v.

FORREST D. MATHEWS, SECRETARY OF HEALTH, EDUCATION & WELFARE, AND BLUE CROSS OF FLORIDA, INC., *Respondents*

SUPPLEMENTAL APPENDIX TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, CONTAINING FEBRUARY 6, 1974 OPINION OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

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13402-2-76

The following is the full text of the February 6, 1974 decision of the United States District Court for the Southern District of Florida, which opinion was omitted from the Petition as originally filed herein:

UNITED STATES DISTRICT COURT,
S. D. FLORIDA

No. 73-804-Civ-JLK.

MOUNT SINAI HOSPITAL OF GREATER MIAMI, INC., *Plaintiff*,

v.

CASPAR W. WEINBERGER, Secretary of Health, Education and Welfare and Blue Cross of Florida, Inc., *Defendants*.

Feb. 6, 1974.

• • •

James G. Roth, Broad & Cassel, Miami Beach, Fla., for plaintiff.

Kelly, Black, Black & Kenny, P. A., Miami, Fla., for defendant Blue Cross of Fla.

JAMES LAWRENCE KING, *District Judge*.

Plaintiff Mount Sinai Hospital brought this action to contest the defendants' right to recover some $6 million in Medicare payments received between 1966 and 1972 for services that the Government has since decided were not covered by the Medicare program. The case presents substantial questions about the scope of Governmental authority and the power of the courts to control its exercise, the decision of which will have important consequences for the administration of the Medicare program and the local community which the hospital serves.

Plaintiff is a non-profit facility located in Miami Beach, Florida, a popular retirement haven for senior citizens

from across the nation, a large percentage of whom are Medicare beneficiaries. Since the inception of the program following enactment of the Social Security Amendments of 1965 (Medicare amendments),[1] the lion's share of Mount Sinai's services have understandably been devoted to meeting the needs of the great number of Medicare recipients in the surrounding community. As even defendants have recognized, Mount Sinai in 1971 received the highest daily income from Medicare of any hospital of comparable size in the United States, and submitted claims to the program the following year for more services than any other facility in the Southeast, irrespective of size.[2]

Mount Sinai has been an institution authorized to furnish Medicare services since the program began on July 1, 1965. To qualify as such a "provider of services," the hospital was required to agree not to charge Medicare beneficiaries for its services, but to accept payment from the Federal Hospital Insurance Trust Fund.[3] Payments were made by defendant Blue Cross of Florida, nominated by Mount Sinai to serve as its "fiscal intermediary," and acting by agreement with the defendant Secretary of the Department of Health, Education and Welfare as his agent in administering the program.[4] From 1966 through 1971, Blue Cross apparently reviewed and allowed, with few exceptions, the bills it received from Mount Sinai for Medicare services rendered during that period.

Plaintiff's problems with Medicare began in the summer of 1972 when Blue Cross learned from the Bureau of Health Insurance of the Social Security Administration that

[1] Social Security Amendments of 1965, Pub.L.No.89-97, §§ 101-111, 79 Stat. 286, amending 42 U.S.C. § 401 et seq. (1964) (codified at 42 U.S.C. §1395 et seq. (Supp. I, 1965)).

[2] Suspension Order of May 10, 1972, paras. 8, 9, at 12.

[3] 42 U.S.C. § 1395cc(a)(1)(A) (1970).

[4] 42 U.S.C. § 1395h (1970).

charges of overutilization of services covered by the program had been made against Mount Sinai by an area physician. With the assistance of the Florida Medical Foundation Peer Medical Review Committee, Blue Cross and the Bureau proceeded to review some 700 patient charts for the year 1970 as a means of ascertaining whether erroneous payments had been made for services excluded from Medicare coverage and of projecting the amount of such overpayments during the entire period from 1966 to 1972. By affidavit of J. W. Herbert, President of Blue Cross, it is now alleged on the basis of that review that an estimated $6,380,587.40 in claims were improperly paid to Mount Sinai for items or services not covered by the program. Defendants specifically charge that Mount Sinai performed medically unnecessary procedures and that hospital stays were longer than required.

On the basis of its investigation, Blue Cross delivered a written suspension order to plaintiff on May 10, 1973, which stated that 15 percent of the Medicare payments coming due to Mount Sinai for current services would henceforth be withheld so that the trust fund could begin to recover the alleged overpayments. The suspension order was predicated on regulations that became effective May 27, 1972, which detail a procedure for instituting such suspensions where there is "reliable evidence" that an overpayment has been made.[5]

Before the suspension could be implemented, plaintiff brought this action for temporary and permanent injunctive relief, challenging the statutory authority for the suspension order as well as the constitutionality of the procedures prescribed by the suspension regulations for its issuance. An emergency hearing was accordingly convened after notice to all the parties on May 17, 1973.

[5] 20 C.F.R. §§ 405.370-405.373 (1973). The regulations became effective prior to the enactment of the Social Security Amendments of 1972. *See* note 6 *infra*.

The evidence presented at the hearing demonstrated that not only Mount Sinai, but the entire community it serves would be irreparably injured by the threatened suspension of Medicare payments. The undisputed testimony indicated that if the suspension order were implemented, Mount Sinai's income could be reduced by as much as $100,000 a week. Such a decrease in the hospital's cash flow would jeopardize its ability to meet weekly payrolls and operating expenses, officials pointed out, because Mount Sinai's capital assets have been fully mortgaged to permit the plant expansion required to meet ever increasing community needs. The impending loss of a major part of the hospital's regular income, they said, would consequently necessitate the discontinuance of such vital, but money-losing, community services as Mount Sinai's medical training program and emergency room operation.

Upon finding that plaintiff had presented evidence sufficient to meet all the prerequisites for temporary relief, the court issued an order intended to preserve the status quo pending further consideration of the case. The order was subsequently extended by stipulation to permit formulation of the issues and decision on a motion to dismiss and on opposing motions for summary judgment to be prepared by the parties. Following the submission of these motions and oral argument thereon, the court further delayed initiation of the suspension with the acquiescence of the parties to permit preparation of this opinion.

Defendants argue in their motion to dismiss that the doctrines of sovereign immunity, ripeness, finality and exhaustion of administrative remedies, as well as the Medicare amendments themselves, prevent the court from hearing plaintiff's claims. We reject that conclusion and deny the motion to dismiss because under none of these theories was it ever intended that the courthouse doors be closed to a litigant in Mount Sinai's shoes confronted with irreparable action and seeking only to prevent what Congress may never have authorized.

There being no genuine dispute as to any fact material to the issue of statutory authority, as the statements of the parties at oral argument and in their opposing motions for summary judgment reveal, we proceed to consider the question of statutory authority. The court independently arrives at the same conclusion expressed by Congress itself when it amended the Act to provide special authority and procedures to determine whether overutilization of Medicare services is occurring, to recover any payments improperly made for such services, and to safeguard the rights of hospitals and other providers of services in the process.[6]

These 1972 amendments were necessary because Congress, when it established the program, provided that if the Government once determined that hospital services were covered by Medicare and proceeded to pay for them, it could not return to the coverage question a second time years later and decide that the same services were not covered. The reason for such a limitation may be explained by the need to encourage hospitals to participate in Medicare despite the requirements that they agree not to charge their patients, but to bill the program for services it covers. By means of the prohibition against reopening coverage determinations, Congress insured that participating hospitals would be protected by prompt notification if the services they had provided were not covered, so that they could immediately proceed to collect from their patients.

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[6] Social Security Amendments of 1972, Pub.L.No. 92-603, § 249F, 86 Stat. 1329, amending 42 U.S.C. § 1301 et seq. (1970) (codified at 42 U.S.C. § 1320c (Supp. II, 1972)). The 1972 amendments apply only to payments made to providers after October 30, 1972, and therefore do not provide authority for recoupment of the payments made to Mount Sinai between July 1, 1966, and January 1, 1972, which are the basis for this dispute. Consequently, all citations herein will be to the Act as it read prior to the 1972 amendments, except as otherwise indicated.

Not until 1972 did Congress grant Medicare the authority to recover funds it had paid to a hospital under the circumstances of this case. Because the payments Medicare now seeks to recover were made between 1966 and 1972, at a time when Congress had not given Medicare the authority to recoup such payments, we hold that defendants are barred from implementing a suspension order against Mount Sinai for those years.

Under the authority granted by Congress in 1972, Medicare can now recover payments resulting from alleged overutilization of services. Consequently, the problem presented in this case will not hereafter arise.

I

Defendants' motion to dismiss must be considered first because it goes to the heart of the court's power to resolve the questions of statutory authority and constitutionality raised by plaintiff's complaint. At the outset it is useful to delimit the precise issues presented by the motion: Whether the court has jurisdiction over this action and, if so, whether that authority should be exercised in this case. Not at issue are such factual problems as whether overutilization of Medicare services actually took place at Mount Sinai between 1966 and 1972, what the extent of the alleged abuses might have been, and whether overpayments to plaintiff resulted.

Plaintiff contends, as the complaint alleges, that the court's power to hear its claims is properly predicated on general federal question jurisdiction [7] and on Section 10 of the Administrative Procedure Act (APA).[8] Defendants respond that this action is barred by the Social Security Act itself and by the doctrines of sovereign immunity,

[7] 28 U.S.C. § 1331 (1970).

[8] 5 U.S.C. § 701 (1970).

ripeness, finality and exhaustion of administrative remedies. We will consider these theories seriatim.

Statutory Preclusion

The limitation on judicial review contained in the original Social Security Act presents the initial impediment advanced by defendants to the court's assumption of federal question jurisdiction. Section 205(h) provides, that subject only to the review afforded by the Act, the results of an administrative hearing are final and may not be relitigated in the courts under federal question or other independent jurisdictional provisions.[9] This limitation was incorporated by reference in Section 1872 of the Medicare amendments, and consequently governs any disputes arising under the program.[10] Because the Act authorizes judicial review pursuant to Section 205(g) for health care facilities in only two instances, neither of which includes

[9] Section 205(h) provides:

> "The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter."

42 U.S.C. § 405(h) (1970). The provision in Title 28 for federal question jurisdiction, 28 U.S.C. § 1331 (1970), was formerly contained in Section 41(1) of that title, and is therefore included within the prohibition of Section 205(h).

[10] Section 1872 provides, in pertinent part:

> "The provisions of . . . subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this [Medicare] sub-chapter to the same extent as they are applicable with respect to [social security disputes in] subchapter II of this chapter."

42 U.S.C. § 1395ii (1970).

the suspension of Medicare payments to a provider of services,[11] defendants assert that Section 205(h) expressly prohibits federal question jurisdiction.

The short answer to this argument is that Section 205(h) must be read in pari materia with Sections 205(b) and 205(g) which complete the statutory scheme for review of Medicare disputes.[12] Section 205(g) conditions the limited judicial review it carefully details on the availability of an administrative hearing and the exercise of that right in accordance with Section 205(b).[13] Likewise, it is only "after a hearing" that Section 205(h) by its terms renders

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[11] Section 1869(c) provides:

> "Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc((b)(2) of this title [terminating its status as a provider], shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title."

42 U.S.C.§ 1395ff(c) (1970).

[12] 42 U.S.C. § 405(b, g) (1970). Both of these provisions apply to Medicare because they are incorporated by the terms of Section 1869(c) of the Act. 42 U.S.C. §1395ff(c) (1970). *See* note 11 *supra*.

[13] Section 205(g) provides in pertinent part:

> "Any individual, *after any final decision* of the Secretary made *after a hearing to which he was a party*, irrespective of the amount in controversy, may obtain a review of such decision by a civil action. . . . The Court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, *with or without remanding the cause for a rehearing*. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive . . . ."

42 U.S.C. § 405(g) (1970) (emphasis added).

decisions of the Secretary binding and unreviewable by any route other than Section 205(g).[14] Where a hearing is authorized, therefore, Section 205(h) serves to prevent the premature disruption of the administrative hearing procedure established by Section 205(b), and to insure that the limited scope of judicial review intended by Section 205(g) is not circumvented by the development de novo of a judicial record unguided by the hand of agency expertise.

It does not follow, however, that Section 205(h) likewise forbids judicial scrutiny where the Act makes no provision for a hearing that is subject to administrative and judicial review. In the absence of any administrative hearing and appeal procedure, there is no need to protect the integrity of the administrative process; and where no administrative record has been prepared, limiting the scope of judicial review fails to serve any paramount purpose.

More weighty are the constitutional considerations which caution against such a broad interpretation of Section 205(h). To suggest that Congress intended to foreclose even judicial review in every case for which it did not provide an administrative hearing is to impute to the legislature a cavalier disregard for the dictates of due process.[15] We therefore concur in the view that "[a]bsent any

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[14] *See* note 9 *supra*.

[15] Of course, a hearing may not be required in every case in which agency action affects a private interest. Conversely, however, it cannot be said with certainty that no hearing will be required in any such case. Whether due process mandates any procedural protection at all of an individual interest depends on whether that interest is within the contemplation of the liberty or property language of the Fifth Amendment, *cf.* Morrissey v. Brewer, 408 U.S. 471, 841, 92 S.Ct. 2593, 33 L.Ed. 2d 484 (1972), citing Fuentes v. Shevin, 407 U.S. 67, 92 S.Ct. 1983, 32 L.Ed.2d 556 (1972), and on whether it is adversely affected by agency action to the extent that the individual will be "condemned to suffer grievous loss." Joint Anti-Fascist Refugee Comm. v. McGrath,

evidence to the contrary, Congress may rather be presumed to have intended that the courts should fulfill their traditional role of defining and maintaining the proper bounds of administrative discretion and safeguarding the rights of the individual." Cappadora v. Celebrezze, 356 F.2d 1, 6 (2d Cir. 1966).

The authority advanced by defendants for reading Section 205(h) as an absolute bar to jurisdiction under any circumstances is consequently unpersuasive. Only two of the four cases they cite so much as suggest that the provision's prohibition of judicial review extends to disputes for which no administrative hearing may be obtained.[16] One decision avoided consideration of the due process problems inherent in such a holding by ruling that nothing prevents actions like this one which are limited to questions of the constitutionality and statutory basis for Medicare determinations. Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co., 311 F.Supp. 405 (E.D. Wis. 1970). The other likewise stopped considerably short of suggesting

341 U.S. 123, 168, 71 S.Ct. 624, 95 L.Ed. 817 (1951) (Frankfurter, J., concurring), quoted in Goldberg v. Kelly, 397 U.S. 254, 263, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970) and in Morrissey v. Brewer, 408 U.S. at 481. Only a case-by-case "determination of the precise nature of the government function involved as well as of the private interest that has been affected by governmental action" can then settle whether the process due is a hearing. Cafeteria & Restaurant Workers Union v. McElroy, 367 U.S. 886, 895, 81 S.Ct. 1743, 1748, 6 L.Ed.2d 1230 (1961). Absent so much as a clear congressional expression of the necessity for committing an unlimited class of administrative determinations completely to agency discretion for summary adjudication, some cases such at this one may arise in which due process could be jeopardized if Congress had precluded any opportunity whatsoever for a hearing. *See* Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663, 667 (2d Cir. 1973).

[16] Soverign immunity, not Section 205(h), defeated jurisdiction in the other two decisions. Johnson v. Johnson, 332 F.Supp. 510 (E.D.Pa.1971); Allen v. Allen, 291 F.Supp. 312 (S.D.Iowa 1968).

that due process would tolerate a complete denial of review to be implied in every case, deciding only that Congress may prohibit judicial consideration of de minimus beneficiary claims to benefits where its intention to do so has been plainly and expressly stated. Kuenstler v. Occidental Life Ins. Co., 292 F.Supp. 532 (C.D. Cal. 1968).

Far from expressing such an intent, the legislative history of the Medicare amendments does little more than paraphrase the language incorporated from Section 205(h) which must be construed by the court. The report of the Senate Finance Committee states that "[i]t is intended that the remedies provided by [the Medicare] review procedures shall be exclusive."[17] Insofar as that observation expresses congressional intent, it explains the Committee's purpose in amending House Bill 6675 to incorporate Section 205(h) by reference; namely, to insulate the Medicare appeal procedure just as review of social security determinations had always been insulated. The statement therefore assumes, rather than defines, the circumstances under which Section 205(h) is to be applied to preclude review. To interpret it as extending the prohibition of judicial scrutiny to cases for which no administrative hearing is available would be to ignore the rule that where agency action is challenged as a denial of due process, it is "immune from judicial review, if ever, only by the plainest manifestation of congressional intent to that effect." Gonzalez v. Freeman, 118 U.S. App. D.C. 180, 334 F.2d 570, 575 (1964) (Burger, J.).[18]

In the absence of more compelling authority, it is difficult to justify according unlimited scope to the Act's pro-

[17] S.Rep.No. 404, 89th Cong., 1st Sess., pt. 1 (1965), *in* U.S.Code Cong. & Admin.News, p. 1995 (1965).

[18] By comparison, the declaration of congressional intent held a bar to review in the *Kuenstler* case spoke directly to the applicability of the provision to the kind of dispute there involved. 292 F.Supp. at 537.

hibition of federal question jurisdiction as a means to the end of barring judicial review. The court is convinced that Section 205(h) was intended to insure the orderly resolution of disputes through procedures the Act established, not to risk frustration of due process by foreclosing judicial consideration of determinations for which Congress provided no reviewable administrative hearing. We therefore join in the construction of the provision adopted by most courts which have considered the question:

> "Where the Medicare Act establishes procedures for review of the Secretary's decision, a court may not review that decision by any other means. However, where the Act does not provide such procedures, section [2]05(h) does not preclude review."

Aquavella v. Richardson, 437 F.2d 397, 402 (2d Cir. 1971), *quoted in* Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663, 666-667 (2d Cir. 1973); *and* Temple University v. Associated Hosp. Serv., 361 F.Supp. 263, 269 (E.D. Pa. 1973).[19]

So construed, the Act presents no bar to the adjudication of this case. Because the amount in controversy unquestionably exceeds $10,000, we hold that this action may be maintained on the basis of federal question jurisdiction. However, the question of whether plaintiff has stated a claim upon which relief can be granted remains to be considered.

Nonstatutory Review

The APA authorizes nonstatutory review of such challenges to administrative determinations as this one through "any applicable form of legal action, including actions for declaratory judgments or writs of prohibitory

[19] *See* Opelika Nursing Home, Inc. v. Richardson, 356 F.Supp. 1338 (M.D.Ala.1973); Coral Gables Convalescent Home, Inc. v. Richardson, 340 F.Supp. 646 (S.D.Fla.1972).

or mandatory injunction . . . in a court of competent jurisdiction.[20] Having held that Section 205(h) does not prohibit federal question jurisdiction, we need not enter the controversy over whether the APA itself vests power in the court to hear this action for declaratory and injunctive relief.[21] There can be no dispute, at least, that this is a court of "competent jurisdiction" because an independent basis for subject matter jurisdiction exists and personal jurisdiction over the defendants has been obtained.[22]

Review cannot be secured under the APA, however, "to the extent that—(1) statutes preclude judicial review; or (2) agency action is committed to agency discretion by law."[23] The latter exception presents no difficulty because defendants have not suggested that the challenged suspension determination is entrusted to agency discretion "to the extent that" the APA would not apply even if there were a clear abuse of authority or procedure. In any event, the exception is inapplicable because the dispute over whether the Act commits issuance of a suspension order exclusively to agency discretion cannot be resolved on the conflicting allegations of the pleadings. Nor did Congress intend the exception to prevent review under the APA except where a statute is "drawn in such broad terms that . . . there is no law to apply," which is not the case here. Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 410, 91 S.Ct. 814, 28 L.Ed.2d 136 (1971).

[20] 5 U.S.C. § 703 (1970).

[21] *See* Warner v. Cox, 487 F.2d 1301, 1305 n. 8 (5th Cir. 1974). For a less recent, but more extensive discussion of the conflict among the circuits on this issue, see Project, Federal Administrative Law Developments—1971, 1972 Duke L.J. 115, 227-33 [hereinafter cited at 1971 Duke Project].

[22] Byse & Fiocca, Section 1361 of the Mandamus and Venue Act of 1962: "Non statutory" Judicial Review of Federal Administrative Action 81 Harv.L.Rev. 308, 327 (1967); 1971 Duke Project, *supra* note 21, at 230 & n. 18.

[23] 5 U.S.C. § 701(a) (1970).

Defendants nonetheless contend that relief cannot be obtained under the APA because the Medicare amendments "preclude judicial review." Although we have held that review is not expressly prohibited by Section 205(h), they advance the alternative argument that it is foreclosed by the doctrine of implied preclusion. Relying on the provisions for review of Medicare determinations in Section 1869 of the Act, defendants submit that Congress, having carefully designated the types of disputes for which judicial review could be obtained, must have intended that no other controversies be reviewable.

We cannot accept such an argument, however, because Congress intended the APA to apply to a wide range of agency action absent "clear and convincing evidence" in a particular statute to the contrary.[24] This presumption of reviewability has resulted in the rule that judicial review "will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress." Abbott Laboratories v. Gardner, 387 U.S. 136, 140, 87 S.Ct. 1507, 1511, 18 L.Ed.2d 681 (1967); Air Line Pilots Ass'n Int'l v. Department of Transportation, 446 F.2d 236, 241 (5th Cir. 1971). The court is not persuaded that the silence of the Medicare amendments on the availability of review for determinations other than those specified in Section 1869 can be considered either a clear or a convincing manifestation of congressional intent. Aquavella v. Richardson, 437 F.2d at 402. We therefore conclude that the APA applies to this action, and that plaintiff has stated a claim for which relief can be granted on the basis of nonstatutory review.

Sovereign Immunity

Defendants argue that the APA, if it provides a presumption of reviewability, does not constitute a waiver of sover-

[24] H.R.Rep.No.1980, 79th Cong., 2d Sess., 41 (1946), *quoted in* Abbott Laboratories v. Gardner, 387 U.S. 136, 140 n. 2, 87 S.Ct. 1507, 18 L.Ed.2d 681 (1967).

eign immunity. In 1961, however, the Fifth Circuit endorsed the contrary view that the "APA makes clear waiver of sovereign immunity in actions to which it applies," and explained that "by providing judicial review in an action brought by 'any person adversely affected or aggrieved by any agency action' Congress permitted suits which under established tests would certainly be barred as suits against the government." Estrada v. Ahrens, 296 F.2d 690, 698 (5th Cir. 1961). Although the continuing vitality in this Circuit of the rule in *Estrada* has been questioned,[25] it has yet to be explicitly overruled.[26]

[25] The Fourth Circuit has expressed the view that this circuit "apparently altered" the APA waiver rule in *Estrada* with its decision in Colson v. Hickel, 428 F.2d 1046 (5th Cir. 1970). Littell v. Morton, 445 F.2d 1207 (4th Cir. 1971); *see also* 1971 Duke Project, *supra* note 21, at 246 n. 67. But see Constructores Civiles de Centroamerica S.A. v. Hannah, 148 U.S.App.D.C. 159, 459 F.2d 1183, 1191 (1972), *citing* Estrada v. Ahrens, 296 F.2d at 698. However justifiable the inference drawn by the Fourth Circuit may be, it leaves unanswered the question of how the *Estrada* waiver rule was "altered"; namely, under what circumstances and to what extent, if any, the rule remains viable and controlling precedent applicable to a case like this one. A recent decision of this Circuit expressly declines to determine whether *Colson* marks a retreat from *Estrada*, holding only that "whatever waiver the APA provides does not extend so far as an action ex contractu for money." Warner v. Cox, 487 F.2d 1301 (5th Cir. 1974).

[26] We are constrained to note that the Fifth Circuit's opinion in *Colson* nowhere adverts to the *Estrada* decision. Plaintiff Colson invoked Section 10 of the APA along with other jurisdictional statutes, 428 F.2d at 1050, but there is no direct evidence that he argued that it served as a waiver of sovereign immunity. *See* Colson v. Udall, 278 F.Supp. 826 (M.D.Fla.1968). Although the Fifth Circuit noted that it was "aware of the decision, and the dissenting opinion, in State of Washington v. Udall [9 Cir., 417 F.2d 1310]," in which the Ninth Circuit rejected the APA waiver theory, the court instead chose to base its ruling that sovereign immunity barred review of a decision of the Secretary

Treating the APA as a waiver of sovereign immunity as in *Estrada* has many virtues. Not the least would be the simplicity and ease of application of the rule in our overburdened courts. Secondly, the prerequisites to review under the APA protect the very interests sovereign immunity serves. Not only is administrative action unreviewable under the APA where "statutes preclude judicial review" or agency action is "committed to agency discretion by law," but the doctrines of ripeness, finality and exhaustion insure that the public business entrusted to administrative agencies will not be unduly burdened. If an increase in judicial review results, it will fulfill a basic policy objective of administrative law by determining administrative arbitrariness in a government which has become increasingly, if unavoidably, bureaucratic.[27]

Nonetheless, we cannot be unmindful of the limitations on *Estrada*, and of the five other circuits that have rejected the

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of the Interior on two "prior decisions of this Court, relying upon decisions of the Supreme Court." 428 F.2d at 1050 & n. 1.

The Supreme Court rulings in which *Colson* placed its reliance concerned claims that governmental takings of private property constituted a denial of due process, despite the availability of an action for just compensation under the Tucker Act. Dugan v. Rank, 372 U.S. 609, 623-625, 83 S.Ct. 999, 10 L.Ed.2d 15 (1963); Malone v. Bowdoin, 369 U.S. 643, 647 & n. 8, 82 S.Ct. 980, 8 L.Ed.2d 168 (1962); Larson v. Domestic & Foreign Commerce Corp. 337 U.S. 682, 697 n. 18, 703 & n. 27, 69 S.Ct. 1457, 93 L.Ed. 1628 (1949).

These decisions are far from irreconcilable with the view that the APA constitutes a waiver of sovereign immunity in actions to which it applies. *See* note 30 *infra*. The Fifth Circuit has since suggested one basis for such a distinction in a decision denying review under Section 10(e) of the APA, 5 U.S.C. § 704 (1970), on the theory that it exempts agency action from review for which the Tucker Act provides "some '. . . other adequate remedy in a court.'" Warner v. Cox, 487 F.2d 1301 (5th Cir. 1974).

[27] For a discussion of the advantages and disadvantages of interpreting the APA as a waiver of sovereign immunity, see 1971 Duke Project, *supra* note 21, at 244-50.

APA waiver theory.[28] Nor can we ignore the fact that since the enactment of the APA in 1946, the Supreme Court has warned that it may not "be deemed an implied waiver of all governmental immunity from suit," Blackmar v. Guerre, 342 U.S. 512, 516, 72 S.Ct. 410, 412, 96 L.Ed. 534 (1952),[29] and decided at least five cases in which sovereign immunity barred attempts to review administrative decisions.[30] Al-

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[28] Littell v. Morton, 445 F.2d 1207, 1213 (4th Cir. 1971); Washington v. Udall, 417 F.2d 1310, 1320 (9th Cir. 1969); Motah v. United States, 402 F.2d 1, 2 (10th Cir. 1968); Twin Cities Chippewa Tribal Council v. Minnesota Chippewa Tribe, 370 F.2d 529, 532 (8th Cir. 1967); Cyrus v. United States, 226 F.2d 416, 417 (1st Cir. 1955). *But see* Scanwell Laboratories, Inc. v. Shaffer, 137 U.S.App.D.C. 371, 424 F.2d 859, 873-874 (1970); Kletschka v. Driver, 411 F.2d 436, 445 (2d Cir. 1969).

We note that the APA did not apply to the decisions of the First, Eighth, and Tenth Circuits and therefore could not operate as a waiver of immunity, because the agency action therein was "committed to agency discretion by law." 5 U.S.C. § 701 (1970). The rulings of the Fourth and Ninth Circuits considered sovereign immunity only to discount its applicability.

[29] Although this much quoted statement appears in the case in dictum, the Court expressly refrained from deciding whether, on the facts, the APA applied at all, much less as a waiver of sovereign immunity, where the Hatch Act arguably committed the challenged action to agency discretion. 342 U.S. at 514, 516.

[30] Hawaii v. Gordon, 373 U.S. 57, 83 S.Ct. 1052, 10 L.Ed.2d 191 (1963); Fresno v. California, 372 U.S. 627, 83 S.Ct. 996, 10 L.Ed. 2d 28 (1963); Dugan v. Rank, 372 U.S. 609, 83 S.Ct. 999, 10 L.Ed. 2d 15 (1963); Malone v. Bowdoin, 369 U.S. 643, 82 S.Ct. 980, 8 L.Ed.2d 168 (1962); Larson v. Domestic & Foreign Commerce Corp., 337 U.S. 682, 69 S.Ct. 1457, 93 L.Ed. 1628 (1949).

None of these decisions is fundamentally inconsistent with the view that the APA waives sovereign immunity in actions to which it applies. In Hawaii v. Gordon, for example, the APA could not have served as a waiver since it was inapplicable on the facts, if not because the state lacked standing, then because the agency action challenged was committed to the sovereign's discretion.

The remaining cases turned on the rejection, in the seminal *Larson* decision, of the argument that review of government takings of private property should be available under the traditional exception to the doctrine of sovereign immunity which permits suits against government officers to remedy unconstitutional

though the Court has since granted review in several cases

agency action. *Larson* stands for the proposition, *inter alia* that by guaranteeing due process to persons aggrieved by a governmental taking through an action for damages in the Court of Claims under the Tucker Act, Congress by law narrowed the officer suit exception, thereby broadening the scope of sovereign immunity and constitutionally permissible agency discretion. 337 U.S. at 697 & n. 18, 703 & n. 27.

The result of these cases would not be altered by holding that the APA constitutes a waiver of sovereign immunity in actions to which it applies, unless the teachings of *Larson* were ignored. It follows from the logic of *Larson* that the APA should not apply to suits to remedy government takings, since such takings have been "committed to agency discretion" by the Tucker Act. 5 U.S.C. § 701(a)(2) (1970). The APA would not be available, therefore, to serve as a waiver of sovereign immunity.

Similarly, the APA waiver approach need not conflict with the limitation in *Larson* on the exception to the doctrine of sovereign immunity which permits suits against government officers as a means of obtaning review of action by an agency that exceeds its statutory authority. The requirements articulated in *Larson* for successfully pleading this exception create what amounts to a presumption that if Congress gave an agency authority to do the sort of act complained of, it intended to authorize the specific action. See notes 31-33 *infra* and accompanying text. Sovereign immunity therefore forecloses judicial examination if a statute authorizes the act complained of or that general sort of action, but does not bar review if the act was prohibited by law.

The same result should follow from the APA waiver rule, because the APA will apply to permit review of such abuses of discretion as actions in excess of statutory authority only where the statute contains standards by which an abuse may be evaluated. Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. at 410. Unless, as *Larson* requires, a plaintiff can plead a statutory standard which forbids the action or sort of action he challenges, therefore, the APA will not apply to waive sovereign immunity and he will be unable to obtain review. Although there might be cases in which a statute would specify standards in authorizing the sort of action complained of, in which case the APA would apply as a waiver of sovereign immunity contrary to the dictates of *Larson*, judicial consideration would properly be focused not on whether there were statutory authority for the action, but on whether, assuming such authority, the agency had abused the discretion afforded by the particular statutory standards.

under the APA without mention of sovereign immunity,[31] it has yet to articulate the operative distinguishing principle. We are therefore constrained to assume, without deciding, that *Estrada* does not control our decision here, and that the doctrine of sovereign immunity demands independent consideration.

There can be no dispute that agents of the sovereign are named as defendants in this action. Kuenstler v. Occidental Life Ins. Co., 292 F.Supp. 532 (C.D. Cal. 1968). But that fact does not determine whether a jurisdictional bar is necessarily interposed by the doctrine of sovereign immunity. The applicability of the doctrine "is to be determined, not by the fact of the party named as defendant on the record, but by the result of the judgment or decree which may be entered . . . ." Larson v. Domestic & Foreign Commerce Corp., 337 U.S. 682, 687 n. 6, 69 S.Ct. 1457, 1460, 93 L.Ed. 1628 (1949), quoting Minnesota v. Hitchcock, 185 U.S. 373, 387, 22 S.Ct. 650, 46 L.Ed. 954 (1902). Sovereign immunity governs "if, 'the judgment sought would expend itself on the public treasury or domain, or interfere with the public administration,' . . . or if the effect of the judgment would be 'to restrain the Government from acting, or to compel it to act.'" Dugan v. Rank, 372 U.S. 609, 620, 83 S.Ct. 999, 1006, 10 L.Ed.2d 15 (1963). The latter test is met by Mount Sinai's request that the court "permanently enjoin the defendants from withholding, suspending or reducing any current or future payments" on authority of the challenged suspension regulations, and we can only conclude that the doctrine of sovereign immunity applies.

Nonetheless, the courts have long indulged the legal fiction that when an agent of the sovereign acts ultra vires

[31] *E. g.*, Citizens to Preserve Overton Park v. Volpe, *supra;* Barlow v. Collins, 397 U.S. 159, 90 S.Ct. 832, 25 L.Ed.2d 192 (1970); Association of Data Processing Serv. Organizations, Inc. v. Camp, 397 U.S. 150, 90 S.Ct. 827, 25 L.Ed.2d 184 (1970); Abbott Laboratories v. Gardner, *supra.*

his statutory or constitutional authority, his actions are not those of the sovereign and equitable relief may be granted against him individually. Such "officer suits" are available in the case of "(1) action by officers beyond their statutory powers and (2) even though within the scope of their authority, the powers themselves or the manner in which they are exercised are constitutionally void." Dugan v. Rank, 372 U.S. at 621-622.

The officer suit exception for action in excess of statutory authority has been given limited scope, however, since the *Larson* decision. Prior to that ruling, if a plaintiff alleged this exception, courts would admit jurisdiction on the pleadings and proceed to a ruling on the merits unless the officer's actions could not be said to exceed the statutory authority pleaded by the government. The *Larson* case in effect shifted the burden from the government to the plaintiff by prohibiting consideration of the merits if the officer demonstrates, by way of a prima facie showing of "general 'authority' to do the *sort* of act complained of,"[32] that his actions "*do not conflict with* the terms of his valid statutory authority."[33] Moreover, it is no longer enough in the wake of *Larson* to invoke the exception by alleging simply that the actions of a government officer are "illegal" or "unauthorized." 337 U.S. at 693. Rather, the plaintiff must specifically "set out in his complaint the statutory limitation on which he relies." 337 U.S. at 690.

Although the tests subsequently applied have varied from circuit to circuit,[34] the Fifth Circuit has found the

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[32] Comment, Immunity of Government Officers: Effects of the Larson Case, 8 Stan.L.Rev. 683, 689 (1956); *see* Project, Federal Administrative Law Developments—1969, 1970 Duke L.J. 67, 204.

[33] 337 U.S. at 695 (emphasis added).

[34] *See* 1971 Duke Project at 237 n. 27. The Ninth and Tenth Circuits, for example, have adopted an administrative discretion analysis under which anything short of an express statutory grant of discretion covering the challenged action is sufficient to render it ultra vires, and thereby adequate to invoke the officer suit exception. *E. g.*, Washington v. Udall, 417 F.2d 1310 (9th Cir. 1969); National Helium Corp. v. Morton, 455 F.2d 650 (10th Cir. 1971).

allegations of the complaint determinative. An officer suit may be maintained if plaintiff's averments are "affirmative" and "explicit" rather than "insubstantial" or "frivolous," and if, assuming their truth for jurisdictional purposes, they demonstrate a "clear, legal duty" imposed by statute on a government officer. Carter v. Seamans, 411 F.2d 767, 770-771 (5th Cir. 1969), cert. denied 397 U.S. 941, 90 S.Ct. 953, 25 L.Ed.2d 121. Mount Sinai's substantial allegations meet this standard not only by affirmatively and explicitly denying that defendants' actions are authorized, but also by citing a provision imposing a contrary duty.[35]

It is impossible to make a prima facie determination of whether defendants are authorized to do "the sort of act complained of" by Section 1815 of the Act upon which defendants rely.[36] Confronted with plaintiff's reliance on a different provision, the court is unable to say whether defendants' actions do or "do not conflict with the terms of [their] valid statutory authority" without considering the merits. We therefore conclude that the complaint sufficiently invokes this officer suit exception to demand inquiry into the merits.

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[35] Mount Sinai alleges, *inter alia*, that "the regulations under which Defendants purport to act . . . are being applied in a manner not authorized by law," and that the 1972 Medicare amendments, here inapplicable, "provide the only statutory basis for imposing a penalty on a retroactive basis against providers of services on the grounds that some of the services provided were not medically necessary." Plaintiff asserts that once payment for services rendered has been made, such attempts at retroactive recoupment are barred by the statutory limitation contained, by way of a condition precedent, in section 1862(a)(1) of the Act which, as the complaint specifically notes, "states that no payment may be made under the Medicare program for any expenses incurred for items or services 'which are not reasonable and necessary.'" 42 U.S.C. § 1395y (a)(1) (1970).

[36] 42 U.S.C. § 1395g (1970).

Sovereign immunity likewise will not defeat jurisdiction over plaintiff's constitutional challenge because it is one of the few due process claims to come within the second officer suit exception. Since *Larson,* the rule has been settled:

> "Where the action against which specific relief is sought is a taking, or holding, of the plaintiffs' property, the availability of a suit [e. g., in the Court of Claims] for compensation against the sovereign will defeat a contention that the action is unconstitutional as a violation of the Fifth Amendment."

337 U.S. at 697 n. 18. Unlike the plaintiff in *Larson,* however, Mount Sinai has no viable legal remedy by which it may obtain compensatory damages for the injury it stands to suffer from defendants' actions. No subsequent legal remedy can conceivably compensate the hospital or the public for the loss of trained personnel and community medical services that will result from implementation of the suspension order.[37]

Notwithstanding the availability of an officer suit, however, sovereign immunity may sometimes remain a jurisdictional bar because of the impact of the relief requested, in accordance with a celebrated footnote to the *Larson* decision:

> "Of course, a suit may fail, as one against the sovereign, even if it is claimed that the officer being sued

[37] The court is aware of no case deciding whether a contract may be implied between a provider of services and the government from section 1866 of the Act, 42 U.S.C. § 1395cc (1970), so that Mount Sinai would have an action for compensatory damages in the Court of Claims. 28 U.S.C. § 1491 (1970). Even if such an action could be maintained, however, we think the remedy would necessarily be inadequate given the impossibility of ascertaining the full extent of the consequential damages occasioned by the suspension order. Moreover, the remedy contemplated by the Medicare regulations would provide reimbursement only for amounts that should not have been withheld, not for consequential losses resulting from the withholding of payments itself. 20 C.F.R. § 405.373(b) (1973).

> has acted unconstitutionally or beyond his statutory powers, if the relief requested cannot be granted by merely ordering the cessation of the conduct complained of but will require affirmative action by the sovereign or the disposition of unquestionably sovereign property."

337 U.S. at 691, n. 11. Nonetheless, Mount Sinai seeks no affirmative government action, but only an end to the suspension order. The fact that Medicare payments would then continue as usual requires no more of the government than the routine distribution of funds concededly due the hospital for services currently rendered, not the "disposition of unquestionably sovereign property."

The application of the *Larson* affirmative impact rule has subsequently been refined, moreover, to require the dismissal only of those actions in which the relief requested would "work an intolerable burden on governmental functions outweighing any consideration of private harm." Washington v. Udall, 417 F.2d 1310, 1318 (9th Cir. 1969); Littell v. Morton, 445 F.2d 1207, 1213 (4th Cir. 1971).[38] Whatever the extent to which the relief Mount Sinai requests might be characterized as affirmative in nature, we conclude on balance that sovereign immunity should not bar this action because it is the burden on the plaintiff and the public, not that on the government, which is an intolerable one.

Nor would the requested relief thwart efforts by Medicare to prevent ongoing overutilization and to recoup any resulting overpayments from Mount Sinai or other providers of services. The Act now expressly provides procedures holding providers accountable for any medically

[38] *See* L. Jaffe, Judicial Control of Administrative Action 226-27 (1965) [hereinafter cited as Jaffe]; 3 K. Davis, Administrative Law Treatise § 27.05, at 571-76 (1958) [hereinafter cited as Davis]; *cf.* Larson v. Domestic & Foreign Commerce Corp., 337 U.S. at 704.

unnecessary services charged to the program after October 30, 1972.[39]

The one serious burden on the government if relief were granted would be frustration of the present attempt to recover alleged overpayments made prior to 1972. That effort, however, can serve only one purpose: To protect the economic viability of the program. Yet defendants do not suggest that Medicare has been placed in any financial jeopardy as a result of the suspected overpayments, or that failure to recoup them will endanger the continued operation of the program. To the contrary, however, costly to the trust fund the relief requested may seem, the Medicare program has survived without visible impairment in the years since the alleged overpayments were made. It therefore appears that the burden on governmental functions has been tolerable, and would hardly become otherwise if relief were granted.

By comparison, the "private" harm to be considered here poses a twofold threat of substantial public injury. First, although the consequences of denying review to Mount Sinai will have no little impact on the hospital's financial condition, the interest of the public it serves will sustain a still greater injury. If the challenged suspension order were held immune from judicial review, the public health and welfare would stand to suffer irrevocable harm from whatever cutbacks in money-losing community services become necessary as a result of the reduction of the hospital's income.

Secondly, there is a broader public interest that would be injured by holding that sovereign immunity bars such a limited action as this one. It has never been thought that even unconstitutional or unauthorized actions by agents of the sovereign should be immunized from judicial review simply because the remedy requested might conceivably

[39] *See* note 6 *supra* and accompanying text.

have an affirmative impact on agency action, no matter how remote it might be. If that were true, the precaution might often prove more deleterious to the public interest than the cost of the cure. Where, as here, the operation of a government program will not be adversely affected, the public interest in insuring lawful agency action should ordinarily prevail. We therefore conclude that the potential injury to the public outweighs any burden on governmental functions which might be imposed if the relief Mount Sinai seeks were granted.

The same balancing of interests supports an alternative theory. There is authority for the proposition that even where an officer suit may be unavailable, sovereign immunity will not defeat an action, which, on balance, does not constitute a "substantial bothersome interference with the operation of government." Littel v. Morton, 445 F.2d at 1214. Either approach supports our holding that the doctrine of sovereign immunity is not so transcending as to require dismissal of this action.

II

Defendants next contend that if neither the Medicare amendments nor the doctrine of sovereign immunity defeats the court's jurisdiction, its exercise must be declined because this action is not ripe, the agency determination challenged is not final, and plaintiff has failed to exhaust its administrative remedies.[40] Although some judicial discussion suggests that these issues have become so interrelated as to mandate a broad balancing of interests,[41] the

[40] Defendants do not suggest, nor could they, that plaintiff lacks standing or that the suspension order is informal action not susceptible to review.

[41] In Aquavella v. Richardson, for example, the Second Circuit commented:

> "Courts have employed the elusive concept of finality, as well as the related and often overlapping doctrines of ripeness and

result has been criticized for occasionally losing sight of important considerations.[42] In the interest of articulating the pertinent factors, we will examine each issue separately.

Ripeness

Ripeness, a judicial construct formulated to prevent the depletion of judicial resources through premature judicial action, has traditionally been thought to have as its focus the crystallization of the legal controversy between the litigants, as opposed to the concern expressed by the doctrine of finality for the integrity of the administrative process.[43] Although the issue of ripeness ordinarily does not arise in the context of adjudicatory proceedings, the interests embodied in the doctrine are always relevant considerations in determining whether to grant nonstatutory review.

In *Abbott Laboratories,* the leading case on the application of the ripeness doctrine, the Supreme Court articulated the elements to be examined in deciding whether the issues are fit for judicial decision.[44] The Court consid-

exhaustion of administrative remedies, to determine whether or when they should inject themselves into the administrative process. While each doctrine has its own nuances, common to all is a careful balancing of the need for effective judicial protection against the need for efficient and responsible administrative action. . . ."

437 F.2d at 403.

[42] 1971 Duke Project, *supra* note 21, at 286-87.

[43] 1971 Duke Project, *supra* note 21, at 278 & n. 14; *cf.* Jaffe, *supra* note 38, at 395.

[44] Although the Court advanced a two step test for ripeness which requires evaluation not only of "the fitness of the issues for judicial decision," but also of "the hardship to the parties of withholding court consideration," 387 U.S. at 149, examination of the latter step will be deferred in the interest of clarity. *See* note 60 *infra* and accompanying text.

ered such factors as whether the issues were predominantly legal rather than factual, whether the impact of the agency action was sufficiently direct and immediate to create a real case or controversy, and whether intervention at a later stage of the agency process might not better serve the interests of judicial economy without causing further serious and unnecessary harm to the petitioner. We therefore turn to an examination of these elements.

The complaint restricts itself to challenging the statutory authority for the suspension order and the constitutional adequacy of the procedures which led to its issuance. Both issues have long been considered purely "legal" questions to be entrusted to the judiciary rather than to executive agencies for resolution.[45] As their opposing motions for summary judgment indicate, neither side argues that disputed issues of fact remain that require further administrative consideration prior to judicial resolution of the issues.[46]

Secondly, the record as it now stands is adequate for the limited review requested, and delay of judicial intervention pending further administrative proceedings would produce no substantial clarification of the issues. The necessary factual foundation for determining the statutory authority question is to be found in the statute itself and its legislative history, rather than in any factual record the agency might prepare.[47] In addition, the constitutional issue is

[45] *E. g.* Abbott Laboratories v. Gardner, 387 U.S. at 149 n. 16; Aquavella v. Richardson, 437 F.2d at 404.

[46] Only the question of whether, as applied, the challenged regulations constitute a denial of due process may present factual issues if it is reached. Defendants do not suggest, however, that those factual issues should first be determined in administrative proceedings.

[47] To the extent that the agency's experience may be relevant, opportunities have been available for its communication to the court in argument or written brief, although defendants have not pointed out to the court any particular factual justification for the regulation.

clearly drawn, and the pertinent facts are supplied by the regulations under which the suspension order was issued.

Thirdly, the impact of the suspension order on the hospital is sufficiently direct and immediate to insure that judicial review at this stage will produce more than an advisory ruling on hypothetical questions. The withholding of Medicare payments due the hospital for services rendered is not simply a distant threat or possibility. Whereas, judicial intervention might have been premature if plaintiff had brought suit when first notified that the agency was considering such action, or if the suspension had been subject to further administrative review prior to implementation, it is timely now. The suspenson will take effect immediately unless judicial review is granted at this point in the agency proceedings.

A more direct and immediate impact could hardly be imagined than the substantial effect which a 15 percent cutback in Medicare payments will have on Mount Sinai's cash flow position. The suspension will certainly work "an immediate and significant change" in the hospital's conduct of its affairs. Abbott Laboratories v. Gardner, 387 U.S. at 153. Nor does Mount Sinai have any realistic means at its disposal by which it might avoid the impact of the cutback in payments. Its assets are fully mortgaged as uncontradicted testimony revealed, and projected donations are budgeted. To bill patients who received the disputed services, if it were possible, would not promptly ameliorate the problem,[48] and to increase charges for non-

[48] Statistical projections were made for the years 1966 to 1972 on the basis of a study of the charges submitted by Mount Sinai for a sample group of patients treated in 1970 whose medical charts were examined. Whether or not Mount Sinai assented to this procedure, which is a matter of dispute, there can be no question that as a result of the use of this method, the hospital has no basis upon which to bill any but the 710 individual patients studied for specific services not covered by Medicare. Moreover, absent a determination that particular charges to a patient are not cov-

Medicare patients to offset the losses would be as unconscionable as it would be unfeasible.[49]

Finally, considerations of judicial economy do not counsel delay in determining the question presented until a later stage of the administrative process. The issues of statutory authority and constitutionality that have been raised are fundamental to the agency's license to proceed, yet the regulations contemplate no hearing on these questions, but only refinement of the overpayment determination which led to the challenged suspension order.[50] There appears little likelihood, therefore, that the issues presented will be mooted by further administrative consideration. It would be a false economy, indeed, that thought to conserve judicial resources at the expense of continued unlawful government action .

The issues therefore appear fit for judicial determination and the controversy ripe for decision. We will post-

ered, Mount Sinai would risk termination from the Medicare program, to the detriment of the many beneficiaries who use the hospital, if it were to attempt to charge its patients during those years for such services. 42 U.S.C. § 1395ee(a)(1)(A) (1970); 20 C.F.R. §§ 405.607(a), 405,614(a)(1) (1973).

[49] Since the great majority of Mount Sinai's patients are Medicare beneficiaries, *see* note 1 *supra*, charges for non-Medicare patients would have to be increased considerably in excess of 15 percent in order to make up the loss of income resulting from implementation of the suspension order. Mount Sinai lacks the option of increasing its charges to Medicare patients because it would risk termination if it did not bill such services to the program, *see* note 47 *supra*, and because it then becomes entitled to receive only the "reasonable cost" of the services rendered. 42 U.S.C. § 1395f(b) (Supp. II, 1972). "Reasonable cost" is defined as the lesser of the "cost actually incurred," 42 U.S.C. § 1395x (v)(1) (Supp. II, 1972), or the "customary charges with respect to such services," 42 U.S.C. § 1395f(b) (Supp. II, 1972), and payment therefore would be withheld in the face of sudden increases in hospital charges. *See generally* 20 C.F.R. §§ 405.401-405.488 (1973).

[50] 20 C.F.R. § 405.373(b) (1973).

pone final resolution of the question, however, to permit an examination of finality, which was considered by the Supreme Court as an element of ripeness in *Abbott Laboratories.*

FINALITY

Defendants contend that their determination to suspend Medicare payments is not "final agency action" within the meaning of the APA, but should rather be characterized as "preliminary" only.[51] The regulation under which the agency has proceeded states that payments to providers of services may be suspended in whole or part when there is "reliable evidence" that an overpayment has been made.[52] A separate regulation provides that the suspension may be rescinded or adjusted as the result of subsequent agency review.[53] Nonetheless, we conclude for

[51] Section 10(c) of the APA provides in part:

"Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review. A *preliminary,* procedural, or intermediate agency action or ruling not directly reviewable is subject to review on the review of the final agency action.

5 U.S.C. § 704 (1970) (emphasis added).

[52] 20 C.F.R. § 405.370(a)(2) (1973) provides in part:

(a) Payments otherwise authorized to be made to providers of services . . . may be suspended, in whole or in part, by an intermediary or a carrier when:

* * *

"(2) The intermediary or carrier has reliable evidence, although additional evidence may be needed for a determination, that such overpayment exists or that the payments to be made may not be correct."

[53] 20 C.F.R. § 405.373(b) (1973) provides:

"Where the suspension is put into effect by reason of § 405.370 (a)(2), the intermediary or carrier will take timely action after such suspension to obtain such additional evidence it may need to make a determination as to whether an overpayment exists or the payments may be made (i. e., evidence from the records of the provider or supplier of services). All reasonable efforts will be made by the intermediary or carrier to expedite such determinations. As soon as such determination is made, the provider or other supplier will be informed and, where appropriate, such suspension will be rescinded or adjusted to take into account such determination. If such suspension is not rescinded, it shall remain in effect . . . ."

The language of this section, unlike that of the remainder of the suspension regulations, is largely precatory rather than mandatory. Although it states that certain actions "will" follow a suspension based merely on reliable evidence, the only mandatory requirement is that the suspension "shall" remain in effect if it is not rescinded.

the reasons which follow that a suspension of Medicare payments based only on reliable evidence must itself be characterized under the APA as final agency action.

In accord with the presumption of reviewability mandated by the APA, "[t]he cases dealing with judicial review of administrative actions have interpreted the 'finality' element in a pragmatic way." Abbott Laboratories v. Gardner, 387 U.S. at 149. In keeping with this functional approach, an agency order need not be the very last administrative ruling in order to be deemed a "final" one. Isbrandtsen Co. v. United States, 93 U.S.App.D.C 293, 211 F.2d 51, cert denied sub nom. Japan-Atlantic & Gulf Conf. v. United States, 347 U.S. 990, 74 S.Ct. 852, 98 L.Ed. 1124 (1954). Moreover, it is not the label affixed to its action by an agency that is determinative of finality, but a realistic appraisal of the consequences of exercising jurisdiction to permit appeal. Isbrandtsen Co. v. United States, 211 F.2d at 55. Such an appraisal, however, must not lose sight of a twofold concern for the proper judicial-administrative separation of power and the integrity of agency processes.[54] It is to a consideration of these two factors that we now turn.

[54] 1971 Duke Project, *supra* note 21, at 278-79 n. 14.

Concern for the Constitutional separation of powers between the judiciary and the executive agencies bridges the conceptual morass between ripeness and finality. Many of the relevant factors, such as the adequacy of the record, the clarity of the issues, and the potential for judicial resolution of the controversy, relate primarily to ripeness or fitness for judicial determination, and need not be reviewed here. Two additional considerations come into focus, however, in conjunction with an examination of finality: The need for uniformity of decision and for the development of agency expertise.

When Congress perceives a need for prompt nationwide uniformity of decision, it may commit to an agency adjudicatory functions it might otherwise entrust to the courts. Yet this congressional concern that substantive regulatory principles receive equal nationwide application does not extend to the questions presented here of statutory authority and the constitutionality of agency action, which the founding fathers entrusted to judicial resolution. We therefore need not consider it further.

Courts must also be concerned that by exercising jurisdiction they will not unduly interfere with an agency's acquisition of administrative expertise pursuant to its congressional mandate. Particular solicitude is appropriate where an agency is first embarking upon a new field of regulation or administration of a novel program.

The substantive factual issues that confront Medicare in its investigation of overutlization, and about which expertise might arguably need to be developed, concern the medical necessity for providing specific treatment in a given case and the reasonable cost of services properly rendered. Yet, defendants have been required to develop reasonable cost expertise since the Medicare program's inception in 1966. If a question of the reasonableness of the costs charged by Mount Sinai were involved in this case, which it is not, defendants would therefore have had

adequate opportunity to acquire the necessary expertise in the subject. Similarly, neither an opportunity nor a need exists for the development of agency expertise to evaluate the medical necessity of the treatment provided.[55] In accord with the apparent intent of Congress, medical determinations were left in this case to a peer review group of physicians.[56] Moreover, although overutilization is a problem which Medicare may again confront in the future, the 1972 amendments provide for its resolution without the development of a special body of agency expertise.[57]

Neither the need for uniformity of decision nor for the development of agency expertise consequently cautions against judicial intervention at this stage of the administrative process in view of the limited, but fundamental issues that have been raised. Not only from the previously examined standpoint of the judiciary, therefore, but also from that of the executive agencies, the proper allocation of authority between their respective branches does not militate against a determination that the disputed agency action is final.

Whether holding that the suspension order meets the test for finality would unduly disrupt the integrity of agency processes remains to be considered. The factors which control are "whether the process of administrative decisionmaking has reached a stage where judicial review will not disrupt the orderly process of adjudication and

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[55] Section 1801 of the Act, for example, contains a specific prohibition of governmental interference in the practice of medicine, the manner in which medical services are provided, and the selection, tenure or compensation of any officer or employee of any institution providing health services to the program. 42 U.S.C. § 1395 (1970).

[56] Suspension Order of May 10, 1973, at 4-5.

[57] *See* note 6 *supra* and notes 133-40 *infra* and accompanying text.

whether rights or obligations have been determined or legal consequences will flow from the agency action." Port of Boston Marine Terminal Ass'n v. Rederiaktiebolaget Trans-Atlantic, 400 U.S. 62, 71, 91 S.Ct. 203, 27 L.Ed.2d 203 (1970).

Courts ordinarily hesitate to disrupt the orderly process of adjudication by intervening in the absence of a final agency decision for two major reasons, each of which subsumes a number of corollary considerations. The first is the need to give wide scope to agency discretion and expertise; the second, the desirability of encouraging the efficient and effective functioning of the administrative process. To the extent that these factors do not pertain to the issues presented, of course, the disruptive effect of the judicial exercise of jurisdiction is correspondingly minimized.

Having created an agency for the purpose of implementing a statutory scheme, Congress must be understood to intend that a factual record be developed and the statute applied in the first instance by the body to which it entrusted the necessary discretion and expertise. Ordinarily, therefore, the agency should be given the first chance to develop the record, exercise its discretion and apply the sum of its experience.

However, the role of agency discretion and expertise, like the need for development of a factual record, diminishes when the issues raised are those of statutory authority and the constitutionality of agency action. The question presented in this case of how much fifth amendment process may be due has been confided by the Constitution to the discretion and expertise of the judiciary, rather than to the agencies of the executive branch. Likewise, the judiciary is the ultimate arbiter of challenges such as this one to the statutory authority for agency action. Although an administrative agency's construction of its governing statute may be entitled to great weight, only the courts may

finally decide the limits of its statutory authority.[58] Where, as here, only issues of statutory authority and constitutionality have been raised, there is no compelling reason to give wide scope to agency discretion and experience.

Before intervening in the administrative process, the courts must also consider society's need to leave administrative agencies free to pursue their congressional mandate in the public interest without continual interruption from individual grievances. Thus, with an eye to agency efficiency and effectiveness, courts normally find it wiser to permit the administrative process and the public business to go forward than to encourage attempts to frustrate agency procedures by offering shelter in the courts at intermediate stages.

Nonetheless, it has been recognized that judicial intervention may be justified at an earlier stage in the administrative process than usual where, as here, there is a substantial showing that an agency has exceeded the authority granted it by Congress, or that it is acting unconstitutionally.[59] The simple reason for this exception is that

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[58] *E. g.*, Social Security Bd. v. Nierotko, 327 U.S. 358, 368-369, 66 S.Ct. 637, 90 L.Ed. 718 (1946); Stark v. Wickard, 321 U.S. 288, 310, 64 S.Ct. 559, 88 L.Ed. 733 (1944); *see* Abbott Laboratories v. Gardner, 387 U.S. at 149. The agency can, in addition, urge its interpretation of the statute upon the court, as it has done here.

[59] *See, e. g.*, Oestereich v. Selective Serv. Bd., 393 U.S. 233, 89 S.Ct. 414, 21 L.Ed.2d 402 (1968); Leedom v. Kyne, 358 U.S. 184, 188, 79 S.Ct. 180, 3 L.Ed.2d 210 (1958); Coca-Cola Co. v. FTC, 475 F.2d 299, 303 (5th Cir. 1973); Templeton v. Dixie Color Printing Co., 444 F.2d 1064, 1068-1069 (5th Cir. 1971); Boire v. Miami Herald Publishing Co., 343 F.2d 17, 20-21 (5th Cir. 1965); Fay v. Douds, 172 F.2d 720 (2d Cir. 1949); *cf.* Public Util. Comm'n v. United States, 355 U.S. 534, 539-540, 78 S.Ct. 446, 2 L.Ed.2d 470 (1958). Although the Fifth Circuit may have construed the precedent narrowly, it has assented to more than a cursory inspection of such challenges:

> "When . . . parties bring suit in District Court alleging the deprivation of specific constitutional rights or, indeed, specific

both the public business and the public interest are advanced by resolving such issues promptly. Although disruption of the administrative process cannot be avoided, the public business stands to benefit from early notice of fundamental defects which would invalidate lengthy agency proceedings upon ultimate review. The public interest is likewise served by timely judicial supervision to insure that administrative action is lawful. Not even considerations of agency efficiency and efficacy, therefore, counsel against the limited review plaintiff seeks in this case.

Injury

The ultimate question courts must answer in determining finality is whether the extent and character of the injury suffered is sufficient under the circumstances of the case to justify disruption of the agency process. The Supreme Court has articulated the test as "whether rights or obligations have been determined or legal consequences will flow from the agency action." Port of Boston Marine Terminal Ass'n v. Rederiaktiebolaget Trans-Atlantic, 400 U.S. at 71.

Substantially the same question, although with different emphasis, requires consideration in determining ripeness under the two-step test enunciated in *Abbott Laboratories*.[60] It is not enough that the injury occasioned by agency action is sufficiently direct and immediate to insure that a real, justiciable controversy exists. Courts must "assess the hardship to the parties if judicial relief is denied" by inquiring whether "irremediable adverse consequences flow

> statutory rights, . . . the Distret Court has jurisdiction to inquire into the preliminary question of whether judicial vindication of the alleged rights is appropriate in a given procedural setting, and if so, whether such rights have been infringed and how they ought to be redressed."

Coca-Cola Co. v. FTC, 475 F.2d at 303 (citations omitted).

[60] *See* note 44 *supra*.

from requiring a later challenge." Toilet Goods Ass'n v. Gardner, 387 U.S. 158, 162, 164, 87 S.Ct. 1520, 1523, 1525, 18 L.Ed.2d 697 (1967).

Both the finality and ripeness injury tests are cut from the same cloth, the jurisprudence of equitable remedies.[61] Yet by focusing on the extent of the harm to the plaintiff, or the timing of the request for judicial intervention, the judicial shorthand of each obscures the balancing of interests which has always been the touchstone for the exercise of judicial discretion in granting equitable relief.

What courts must and do consider does not stop with the question of the character and extent of the individual injury occasioned by agency action. The adverse effect on the agency and the judiciary of granting review must also be weighed, as well as whether the public interest argues for or against judicial intervention. Consequently, no hard and fast rule can define either finality or ripeness in terms of the injury to the aggrieved party. Any attempt to formulate such an objective standard simply expresses a conclusion about the appropriate balance in a particular case.

However characterized, the injury confronting Mount Sinai if review were denied at this stage of the suspension proceedings would be serious enough to foreclose a legal right. If the disputed services provided by the hospital are finally determined not to be covered by Medicare, Mount Sinai would acquire the right to collect for them from its former patients.[62] However, the fact that the contested suspension order by its own terms represents no more than a tentative determination of non-coverage operates to defeat the hospital's right. Daily prejudice to Mount Sinai's ability to collect from its patients is occa-

[61] *See* Abbott Laboratories v. Gardner, 387 U.S. at 148; Jaffe, *supra* note 38, at 410-411.

[62] 42 U.S.C. § 1395cc(a)(2) (1970). See notes 121-22 *infra*.

sioned by delay in the final determination, given the advanced age and declining health of the program's beneficiaries. Because the suspension order thereby works to foreclose the hospital's right to collect for services rendered as long as six years ago, it finally "determines a legal right."

Moreover, even if that right were not effectively foreclosed, its exercise could do little to moderate the immediate financial injury Mount Sinai will incur in the absence of judicial intervention. The loss of as much as $100,000 a week from the 15 percent cutback in Medicare payments contemplated by the suspension order will have a severe impact on Mount Sinai's cash flow position, requiring reductions in its staff and in the community services it now performs.

To be sure, there is some authority for ending our inquiry at this point in reliance on the rule that "a threat of economic injury has always been regarded as sufficient . . . for the purpose of finding an order final and reviewable." Environmental Defense Fund v. Ruckelshaus, 142 U.S. App. D.C. 74, 439 F.2d 584 (1972). Like all other injury tests, however, this precept expresses no more than a conclusion about the appropriate balance among the competing factors in a particular case. Claims of financial hardship constitute only one symptom of injury, and a difficult one to evaluate at that. According them priority in judicial analysis creates the misimpression that prompt judicial review of agency action may be obtained only by a fortunate few with much to lose. The extent to which such a financial injury test may serve to denote the result in this or other cases equally depends on how much any adverse effect on the public interest, the judiciary, and the agency, weighs against granting review.

Whether affording judicial review to Mount Sinai at this stage of the suspension process would do a disservice to the public interest is a debatable issue. Suspension procedures, which Congress ordinarily authorizes expressly,

are designed to provide an administrative procedure for protecting the public health, safety and welfare in emergency situations. Orders issued in accordance with such authority have consequently received a great measure of judicial deference, particularly where the individual injury they occasion is no more than a private economic interest in business profits.[63]

By comparison, not only does the suspension procedure Mount Sinai challenges lack express congressional authorization, but it protects a financial interest that operates to defeat, rather than promote, the public health and welfare. Alhough the importance of preserving the economic viability of the Medicare program cannot be denigrated, it must compete in this case with the harm to the public health and welfare that would follow from the hospital's reduction or discontinuance of vital public services as a result of the suspension order.

Moreover, the potential jeopardy to the economic viability of the Medicare program would be slight if implementation of the suspension order were delayed by judicial review. If defendants were ultimately to prevail in the action, the postponement of their ability to collect any overpayments finally determined to exist would not itself jeopardize the recovery of those sums.[64] The Medicare amend-

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[63] *See, e. g.*, Nor-Am Agricultural Prod., Inc. v. Hardin, 435 F.2d 1151 (7th Cir. 1970) (en banc).

[64] Defendants do not argue that Mount Sinai's financial future is so uncertain that delay in implementing the suspension would seriously compromise their ability to recoup the alleged overpayments if they should prevail, or that some form of security would not adequately serve to protect Medicare's interest in the interim. To the contrary, the testimony of record reflects that Mount Sinai possesses assets in the neighborhood of $97 million, and there is no indication that it could not readily survive foreseeable contingencies less drastic than the impending 15 percent suspension of its income from services previously performed. This is consequently a much different case from that which would be presented if Medi-

ments provide extraordinary remedies for recouping payments made for non-covered services from individual beneficiaries and their relatives should attempts to recover from the hospital prove unsuccessful.[65] Under these circumstances, we think that the public interest in health and saftey served by Mount Sinai outweighs the public interest in immediately restoring alleged overpayments to the Medicare program.[66]

Whether the injury Mount Sinai stands to suffer in the absence of judicial review outweighs the concerns represented by the concepts of finality and ripeness remains to be considered. Of course, it is not the individual injury to the hospital, strictly speaking, that is determinative. Rather, the individual attempt to invoke judicial review must be weighed as an expression of the public interest in obtaining access to the courts to secure relief from allegedly unlawful agency action.

As the court's discussion of the considerations underlying the doctrine of finality concluded, the integrity of the administrative process would not be seriously jeopardized if the limited review requested were granted. We think the modest disruption necessary would be more than outweighed by the harm from the "legal consequences [which] will flow" from denying review, and accordingly hold that the suspension determination is a final order within the meaning of the APA.

Likewise, any potential impediment to the fitness of the issues for judicial resolution is removed by the narrow

care sought to recover funds from a small, privately owned nursing home with meager assets, where delay might well defeat any future recovery, thereby compelling the conclusion that no "court would interfere at [the initial suspension] stage if there were regulations providing a reasonably prompt administrative review of the preliminary action." Aquavella v. Richardson, 437 F.2d at 404.

[65] 42 U.S.C. § 1395gg (1970).

[66] *See* Aquavella v. Richardson, 437 F.2d at 402 n. 15; *cf.* Environmental Defense Fund v. Ruckelshaus, 439 F.2d at 592.

scope of review sought by Mount Sinai. The concerns articulated in the foregoing discussion of ripeness, moreover, are vastly overshadowed by the "irremediable adverse consequences" of the injury both to the public and the hospital which implementation of the suspension order will produce. We consequently hold that this controversy is ripe for judicial resolution.

To say this much, however, is not to imply that any agency action that is involved in a ripe controversy is necessarily final.[67] Although finality and ripeness share a common concern for the injury occasioned by agency action, the countervailing factors differ. Ripeness balances the injury suffered against the fitness of the issues for judicial consideration. Finality weights the injury against the harm to the integrity of the administrative process that would result from judicial intervention. There is no guarantee, therefore, that the same result will emerge from balancing both of these factors, although that happened to be the case here.

Having held that the challenged suspension order constitutes final agency action and that plaintiff's claims are ripe for judicial review, we need consider only one last obstacle to the exercise of jurisdiction. Defendants contend that this action must be dismissed, if for no other reason, because plaintiff has not exhausted its administrative remedies.

EXHAUSTION

The doctrine that administrative remedies must be exhausted prior to judicial review of agency action is a well established principle of judicial administration. Myers v. Bethlehem Shipbuilding Corp., 303 U.S. 41, 50-51, 58 S.Ct. 459, 82 L.Ed. 638 (1938). The general rule, formulated early in this century, is that failure to appeal an agency

[67] In view of the prevailing judicial shorthand it is not surprising that at least one commentator has reached this conclusion. 1971 Duke Project, *supra* note 21, at 286-87.

decision within the administrative process precludes judicial review. United States v. Sing Tuck, 194 U.S. 161, 24 S.Ct. 621, 48 L.Ed. 917 (1904). Interpreted as an expression of executive and administrative autonomy,[68] and as a matter of comity,[69] the principle applies not only where the governing statute makes administrative appeal procedures exclusive, but also where the requirement of exclusivity is not so explicitly mandated. McKart v. United States, 395 U.S. 185, 193, 89 S.Ct. 1657, 23 L.Ed.2d 194 (1969).

Although care must be exercised to distinguish the different situations in which it applies and the factors which require consideration in each, the exhaustion doctrine has long been held a bar to judicial review of interlocutory agency decisions while the administrative process continues.[70] Defendants accordingly invoke the doctrine here as an alternative to finality, arguing that if the suspension order constitutes final agency action, judicial review cannot be granted until Mount Sinai exhausts the remaining procedures provided by the suspension regulations for administrative review of the order.

Although it may be an oversimplification to say that problems of exhaustion begin where questions of finality end under the APA, the factors to be weighed by the courts are substantially identical in review of an interlocutory

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[68] Jaffe, *supra* note 38, at 425.

[69] 1971 Duke Project, *supra* note 21, at 293; *see* Comment, Exhaustion of Administrative Remedies, 39 Cornell L.Q. 273, 292-93 (1954).

[70] *See generally* Davis, *supra* note 38, § 20.05. It is only in a loose sense that exhaustion creates, as defendants contend, a jurisdictional bar to judicial action. Jurisdiction properly refers to the power of the court to act, whereas exhaustion concerns the appropriate timing of its action, a matter subject to the sound discretion of the court once it has the power to act at all. Bannercraft Clothing Co. v. Renegotiation Board, 151 U.S.App.D.C. 174, 466 F.2d 345, 354 (1972); Smith v. United States, 199 F.2d 377, 381 (1st Cir. 1952); *see* Jaffe, *supra* note 38, at 425.

agency decision.[71] The difference is that where Congress has mandated an administrative appeal procedure or expressly authorized its creation, courts are properly more reluctant to intervene than if confronted with final action for which an agency appeal has not been provided. Administrative appeal provides an added opportunity for plaintiff's claims to be vindicated, thereby mooting the controversy and conserving judicial effort. Moreover, the appellate procedure provides at least some evidence of congressional intent to achieve uniformity of decision, encourage development of agency expertise, leave a wide berth for the exercise of agency discretion, and prevent disruption of the administrative process.[72]

Even where congressional intent is not expressed by statutory provision of a procedure for administrative appeals, judicial restraint and a concern for executive autonomy require consideration in the name of exhaustion of substantially the same factors that inform a determination of finality. Although the suspension regulations at issue in this case were propounded by Medicare, rather than provided by Congress, there is no need to reiterate the reasons previously articulated as a basis for the conclusion that the suspension order is a final one. The same considerations support our holding that Mount Sinai need not exhaust further administrative remedies before it will be entitled to judicial review.

The exhaustion rule has traditionally come into play, moreover, only when the administrative remedy provided is adequate to protect the claim which is asserted.[73] The remedy contained in the suspension regulations is deficient in two respects. In the first place, where an aggrieved party must await at its risk such further enforcement pro-

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[71] *See* Jaffe, *supra* note 38, at 425. Where an administrative action lacks finality, of course, the question of exhaustion need not be reached.

[72] *See* McKart v. United States, 395 U.S. at 193-195.

[73] Jaffe, *supra* note 38, at 426.

cedures as the agency may choose to initiate, no viable remedy has usually been thought to be available. Frozen Food Express v. United States, 351 U.S. 40, 76 S.Ct. 569, 100 L.Ed. 910 (1956).[74] The suspension regulations under which defendants have proceeded against Mount Sinai authorize the subsequent review of a suspension order, but do not require in mandatory terms that one be held.[75]

Secondly, an administrative remedy is deemed inadequate if it fails to protect against irreparable injury.[76] Although that criterion is not satisfied simply by the expense of litigation, however great it may be, Myers v. Bethlehem Shipbuilding Corp., 303 U.S. at 51-52, there is authority for the view that financial injury resulting from the forfeiture of a right may be considered irreparable.[77] If the substantial financial loss that Mount Sinai stands to suffer from the suspension of even a portion of the payments righfully due it for current services does not qualify, the non-financial injury to the community which will be occasioned by the resulting cutback of hospital services is surely irreparable. For these traditional reasons, therefore, the exhaustion doctrine does not present a bar to judicial review in this case.

However, Section 10(c) of the APA is equally dispositive of the exhaustion issue presented here. United States v. Consol. Mines & Smelting Co., 455 F.2d 432, 438-440 (9th Cir. 1971).[78] It provides that in the absence of an express

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[74] *Cf.* Columbia Broadcasting Sys., Inc. v. United States, 316 U.S. 407, 62 S.Ct. 1194, 86 L.Ed. 1563 (1942); *see generally*, Jaffe, *supra* note 38, at 426 & nn. 6, 7.

[75] See *note* 53 *supra*.

[76] Jaffe, *supra* note 38, at 428-29.

[77] Jaffe, *supra* note 38, at 429-30; *see* Deering Milliken, Inc. v. Johnston, 295 F.2d 856 (4th Cir. 1961).

[78] *See* 1971 Duke Project, *supra* note 21, at 292-300; Davis, *supra* note 38, § 20.08.

statutory mandate to the contrary, a party subjected to otherwise final agency action that is immediately operative need not exhaust its administrative remedies as a prerequisite to judicial relief.[79]

We are constrained to acknowledge, however, that from the time of the enactment of the APA until recently, the courts have continued to apply the exhaustion doctrine in light of its judicial genesis, leaving Section 10(c) "almost completely ignored."[80] Moreover, few commentators have perceived the provision as a substantial change in the law,[81] but have adhered to the view expressed in government reports[82] and commentaries[83] contemporary to the passage of the APA that the provisions of Section 10(c) "involve no

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[79] Section 10(c) provides in pertinent part:

"Except as otherwise expressly required by statute, agency action otherwise final is final for the purposes of this section whether or not there has been presented or determined an application for a declaratory order, for any form of reconsideration, or, unless the agency otherwise requires by rule and provides that the action meanwhile is inoperative, for an appeal to superior agency authority."

5 U.S.C. § 704 (1970).

[80] Davis, *supra* note 38, § 20.08 at 101; *see* 1971 Duke Project, *supra* note 21, at 293.

[81] *But see* Davis, *supra* note 38, § 20.08 at 101.

[82] S.Doc.No.248, 79th Cong., 2d Sess. 213, 230 (1946) (statement by Attorney General Tom C. Clark); *id.* at 369 (statement by Congressman F. Walters, Chairman, Subcommittee on Administrative Law, Committee on the Judiciary, during House proceedings prior to enactment of APA) [hereinafter cited as S.Doc.No.248].

[83] *See* Brown, The "Federal Administrative Procedure Act," 1947 Wis.L.Rev. 66, 83; Netterville, The Administrative Procedure Act: A Study in Interpretation, 20 Geo. Wash.L.Rev. 1, 30 (1951); Reich, The Federal Administrative Procedure Act, 8 Fed.B.J. 7, 20 (1946); Comment, Judicial Review Under the A.P.A.—In Which Judicial Offspring Receive a Congressional Confirmation, 23 Notre Dame Law. 501, 524 (1948).

departure from the usual and well-understood rules of procedure in this field."[84] Yet the legislative history plainly manifests a congressional purpose that may have been at variance with the judicial view of exhaustion.[85] Both the House and Senate reports delineate the intended operation of the provision, as well as the reasons for its enactment, by explaining that "[t]here is a fundamental inconsistency in requiring a person to continue 'exhausting' administrative processes after administrative action has become, and while it remains, effective."[86]

None of the statutory qualifications attached to the operation of this sound congressional policy apply to this case. The Medicare amendments contain no express statutory countermand to Section 10(c) that governs here, and the action before the court is, as we have ruled, a final one. Lastly, the decision to begin withholding 15 percent of plaintiff's Medicare payments, far from being stayed by rule or regulation pending subsequent review, is immediately operative.[87] Thus, both congressional intent, as it is

[84] S.Doc.No.248, *supra* note 82, at 369.

[85] In an amendment to the APA retained in the final version of S. 7, the House Committee on the Judiciary added the clause, "and provides that the action meanwhile shall be inoperative." S.Doc. No.248, *supra* note 82, at 289. The footnote to the amendment demonstrates that the plain meaning of the added language was intended by the Committee. *Id.* at 289 n. 21.

[86] S.Doc.No.248, *supra* note 82, at 213 (Senate report), 277 (House report).

[87] The requirement that agency action be "inoperative" pending administrative review is thought to refer only to agency actions that would disturb the status quo. Davis, *supra* note 38, § 20.08 at 105-06; *see* 1971 Duke Project, *supra* note 21, at 294 & n. 13. This reading is supported by the conclusions of the Attorney General's office:

> "The last clause of section 10(c) relates to two situations. First, pursuant to section 8(a), an agency may permit its hearing examiners to make initial decisions which will become the agency's final decisions in the absence of an appeal to or review by the agency. The last clause of section 10(c) permits an agency to require *by rule* that in such cases parties who are dissatisfied with the 'initial' decisions of hearing officers must appeal to the agency before seeking judicial review, but only if the agency further provides that the hearing officers' decisions shall be inoperative pending such administrative appeals. * * * (emphasis in original)
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> "The second and similar application of the last clause of Section 10(c) relates to appeals from agency decisions to a superior agency authority. For example, under some circumstances, it would seem that a bureau or other subdivision within an agency may itself be the agency with respect to a particular function. In such a situation, it may be desired to require appeal from the bureau's decision to the department head or other 'superior agency authority' as a prerequisite to judicial review. Under section 10(c), such a requirement may be imposed, but only as in the case of required appeals from hearing officers' initial decisions, if the agency's decision is inoperative pending such appeal."

Atty. General's Manual on the Administrative Procedure Act 104, 105 (1947).

manifested in the APA, and the judicially created exhaustion doctrine independently require the conclusion that exhaustion is inapplicable as a bar to plaintiff's claim.

On the basis of our foregoing conclusions that neither the Medicare amendments nor sovereign immunity precludes federal question jurisdiction, and that none of the doctrines of ripeness, finality and exhaustion of administrative remedies forecloses nonstatutory review under the APA, we conclude that defendants' motion to dismiss must be denied, and it is so ordered. There being no genuine issue as to any fact material to the question, we will proceed to examine the merits of Mount Sinai's claim that defendants lacked statutory authority to issue the suspension order.

III

Statutory Authority

Defendants contend, first, that no explicit statutory authority for the challenged suspension order is necessary because the government has always had the common law and equitable right to extinguish a debt due it by withholding money it owes its debtor. Plaintiff responds that this argument begs the question it purports to answer because it assumes that the government possesses the statutory authority to determine that a debt exists.

The time honored proposition which defendants invoke does not require, however, that the government possess an express statutory grant of authority to determine that a debt is owed.[88] It is well settled that the sovereign has inherent authority to recover sums illegally or erroneously paid,[89] and that it cannot be estopped from doing so by the mistakes of its officers or agents.[90]

Yet, it cannot be doubted that Congress has the power to abrogate that ancient common law right either expressly or by implication if it chooses to do so for some overriding legislative purpose in the interest of the gen-

[88] *E. g.* United States v. Wurts, 303 U.S. 414, 415, 58 S.Ct. 637, 82 L.Ed. 932 (1938); United States v. Bank of Metropolis, 15 Pet. 377, 401, 10 L.Ed. 774 (1841); Fansteel Metallurgical Corp. v. United States, 172 F. Supp. 268, 270-271, 145 Ct.Cl. 496 (1959); Anderson v. United States, 123 F.2d 13 (9th Cir. 1941).

[89] *E. g.* Fansteel Metallurgical Corp. v. United States, 172 F.Supp. at 270-271; United States v. Wurts, 303 U.S. at 415; United States v. Carr, 132 U.S. 644, 651, 10 S.Ct. 182, 33 L.Ed. 483 (1890); United States v. Barlow, 132 U.S. 271, 281-282, 10 S.Ct. 77, 33 L.Ed. 346 (1889).

[90] *E. g.* Federal Crop Ins. Corp. v. Merrill, 332 U.S. 380, 383-384, 68 S.Ct. 1, 92 L.Ed. 10 (1947); Posey v. United States, 449 F.2d 228, 234 (5th Cir. 1971); Heidt v. United States, 56 F.2d 559, 560 (5th Cir.), cert. denied, 287 U.S. 601, 53 S.Ct. 8, 77 L.Ed. 523 (1932).

eral public welfare.[91] What defendants' argument assumes, therefore, is that Congress did not in the Medicare amendments limit the government's authority to determine that payments illegally made may be recovered from a provider of services.

The Medicare amendments contain several indications that such an assumption may be unwarranted. The all-encompassing statutory scheme of this major piece of social welfare legislation is itself a substantial departure from the common law. So, too, is the fact that it limits the traditional liability of government officers and agents for making illegal payments of public funds.[92] Moreover, the Act requires the Secretary to enter into agreements in the nature of contracts with medical care facilities, and regulates the respective rights and duties of the parties in considerable detail.[93] Foremost among those provisions is the Secretary's right to make adjustments for overpayments in certain situations,[94] a stipulation Congress need hardly have enacted had it intended to give unlimited scope to the common law prerogative of government officers to recover illegal payments by set-off. We therefore turn to a consideration of the statute itself.

[91] The power of Congress under the general welfare clause to authorize spending of the public funds for a public purpose if not plenary, is nonetheless broad. U.S.Const. art. I, § 8; *see, e. g.*, Carmichael v. Southern Coal & Coke Co., 301 U.S. 495, 57 S.Ct. 868, 81 L.Ed. 1245 (1937). Even if it could be said that to prohibit any recoupment whatsoever of payments illegally made were such "a display of arbitrary power, not an exercise of judgment" as to exceed that power, Helvering v. Davis, 301 U.S. 619, 640, 57 S.Ct. 904, 908, 81 L.Ed. 1307 (1937), Congress surely has the authority to delimit when and from whom such recoupment may be obtained.

[92] 42 U.S.C. §§ 1395h(g), 1395u(e) (1970).

[93] 42 U.S.C. §§ 1395f(a), 1395h, 1395cc (1970).

[94] 42 U.S.C. § 1395g (1970).

In promulgating the regulations upon which the suspension order is based, the Secretary relied on the substantive authority of Section 1815 of the Medicare amendments.[95] That section provides for payment of providers for services rendered, "with necessary adjustments on account of previously made overpayments or underpayments."[96] But to focus on the language of Section 1815 in isolation as blanket authority for any sort of administrative adjustment is to ignore its limited role within the entire statutory scheme.

Section 1814 of the Act requires that providers of services be paid only the "reasonable cost" of services rendered to Medicare beneficiaries.[97] Section 1861(v) requires that regulations be promulgated for the determination of "reasonable cost," and authorizes establishment of a

[95] 37 Fed.Reg. 89 (Jan. 5, 1972).

[96] Section 1815 reads as follows:

> "The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

42 U.S.C. § 1395g (1970).

[97] 42 U.S.C. § 1395f(b) (1970). The 1972 amendments modify this requirement by authorizing providers to be paid "the lesser of the reasonable cost of the services rendered or the provider's customary charge for such services." 42 U.S.C. § 1395f(b) (Supp. II, 1972), amending 42 U.S.C. §1395f(b) (1970).

method of payment based on cost estimates.[98] The first

[98] As originally enacted, Section 1861(v)(1) provided:

> "The *reasonable cost* of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. *Such regulations* may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, *may provide for the use of estimates of costs of particular items or services*, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. *Such regulations shall* (A) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and *(B) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.*"

42 U.S.C. § 1395x(v)(1) (Supp. I, 1965) (emphasis added). This section, too, was amended in 1972 to define "reasonable cost" as the "cost actually incurred" by the provider. 42 U.S.C. § 1395x(v)(1) (Supp. II, 1972), amending 42 U.S.C. § 1395x(v)(1) 1970).

regulations promulgated when the Medicare amendments became effective made immediate use of that authority.[99]

More importantly, Section 1861(v) clarifies the intended scope of the Secretary's authority under Section 1815 to make "adjustments" for overpayments or underpayments. It not only contemplates, but expressly mandates, that provision be made in the Medicare regulations for "suitable retroactive *corrective adjustments* where, for a provider of services *for any fiscal period*, the aggregate reimbursement produced by the methods of determining *costs* proves to be either inadequate or excessive."[100] Thus, the adjustments envisioned by the Act are intended only to reconcile amounts determined to be due as reasonable costs with amounts actually paid on the basis of cost estimates at the end of the fiscal period. The initial regulations issued by the Secretary accord with this congressional mandate.[101]

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[99] The regulations provide, in pertinent part:

> "*Amount and frequency of payment.* Title XVIII of the act states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be determined until the end of the accounting period, *the providers must be paid on an estimated cost basis* during the year. While the law provides that interim payments shall be made no less often than monthly, intermediaries are expected to make payments on the most expeditious basis administratively feasible. Whatever estimated cost basis is used for determining interim payments during the year, *the intent is that the interim payments shall approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible.*"

20 C.F.R. § 405.454(b), 31 Fed.Reg. 14819 (Nov. 22, 1966) (emphasis added).

[100] 42 U.S.C. § 1395x(v) (1970) (emphasis added).

[101] In pertinent part, the regulations stated:

> "*Retroactive adjustment.* (1) Title XVIII of the Act provides that providers of services shall be paid amounts determined to be due, but not less often than monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs. *Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made* to the provider during the period *into agreement with the reimbursable amount payable* to the provider for the services rendered to program beneficiaries during that period."

20 C.F.R. § 405.454(f)(1) (1973), 31 Fed. Reg. 14819 (Nov. 22, 1966) (emphasis added).

[102] 42 U.S.C. § 1395g (1970) (emphasis added).

Viewed within the framework of the statutory scheme, therefore, it becomes apparent that the authorization upon which defendants rely in Section 1815 for "necessary adjustments" is necessitated by two other provisions of that section. On the one hand, Section 1815 requires the Secretary to "*periodically* determine the *amount which should be paid* [under Part A] to each provider of services with respect to the services furnished by it . . . ." On the other, the section mandates that "the provider of services shall be *paid . . . not less often than monthly* and prior to audit or settlement by the General Accounting Office."[102] The provision for adjustments due to overpayments or underpayments simply recognizes and reconciles the conflicting demands of Section 1815 for periodic settlement of the reasonable cost due when the necessary data becomes available, yet for sufficient frequency of payment to generate an adequate cash flow for the provider.

If Section 1815 may be construed to authorize adjustments for purposes other than that of reconciling cost determinations, reliance upon it to justify the challenged suspension regulations presents two problems arising from its stautory context. First, unlike the minor adjustments envisioned by the Act, the suspension regulations issued in 1972 contemplate cutbacks amounting to a complete termination of all payments due a provider. They state that

current payments may be suspended "*in whole* or in part."[103] Yet the first regulations promulgated after the Act's passage to implement the very provision upon which the regulations rely states that "the intent is that the interim payments shall approximate actual costs as nearly as practicable so that the retroactive adjustment based on actual costs will be *as small as possible.*"[104] The scope of the suspension regulations therefore appears to exceed that of the statutory authorization for adjustments.

Secondly, the retroactivity intended by Section 1861(v) to be accorded corrective adjustments is limited by its terms to "any fiscal period."[105] Although Section 1815 commits the question of a suitable period within which to complete reasonable cost determinations to the Secretary's discretion, he has exercised that authority. The initial regulations issued provided that "interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period."[106] Thus, although the Act contemplates that adjustments will be retroactive, retroactivity is limited to the "end of the accounting period." It does not appear to extend, as defendants would have the regulations extend here, to permit the reopening of final settlements consummated up to six years ago.

Mount Sinai consequently argues that the adjustments for overpayments and underpayments resulting from interim estimates of reasonable cost provide no statutory basis for the challenged suspension regulations. Plaintiff points out that the suspension procedures are not designed to permit reopening of questions of reasonable cost as was

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[103] 20 C.F.R. § 405.370(a) (1973) (emphasis added).

[104] 20 C.F.R. § 405.454(b) (1973) (emphasis added).

[105] 42 U.S.C. § 1395x(v)(1) (1970).

[106] 20 C.F.R. § 405.405(c) (1973).

contemplated in Sections 1815 and 1861(v) of the Act, but rather to allow reconsideration of questions of coverage.

There can be no dispute that defendants have neither administratively determined nor subsequently asserted here that Mount Sinai has overcharged for its services. To the contrary, in accordance with the suspension regulations, they seek only to recoup sums previously paid to Mount Sinai on the basis of a subsequent determination that services concededly rendered are not within the coverage of the Medicare amendments.

Defendants contend, however, that because Section 1815 does not expressly preclude retroactive adjustments on questions of coverage, as opposed to those plainly envisioned for cost adjustments, such inconsistencies as have been noted should not be deemed to bar administrative adaptation of the adjustment procedure to meet contingencies unforeseen at the time of the passage of the Medicare amendments. The force of the argument that when it enacted the program, Congress must have intended to provide wide latitude in the administration of Medicare certainly cannot be ignored.[107]

Indeed, the suspension regulations are not predicated solely on Section 1815, but also rely on the authority of Sections 1102 and 1871 of the Act.[108] Read together, these two sections authorize the promulgation of such regulations as may be necessary to the efficient administration of the Medicare program, so long as they are not inconsistent

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[107] *See, e. g.*, Mourning v. Family Publications Serv., Inc., 411 U.S. 356, 369, 93 S.Ct. 1652, 36 L.Ed.2d 318 (1973); Thorpe v. Housing Authority, 393 U.S. 268, 280-281, 89 S.Ct. 518, 21 L.Ed.2d 474 (1968); *see also* American Trucking Ass'n, Inc. v. United States, 344 U.S. 298, 73 S.Ct. 307, 97 L.Ed. 337 (1953). *But see* NLRB v. Brown, 380 U.S. 278, 291, 85 S.Ct. 980, 13 L.Ed.2d 839 (1965); Celebrezze v. Kilborn, 322 F.2d 166 (5th Cir. 1963).

[108] 37 Fed.Reg. 89 (Jan. 5, 1972).

with the statute.[109] Nonetheless, upon careful consideration of the entirety of the Act, the court is persuaded that the suspension regulations are fundamentally at odds with the intent of Congress as it is manifested by the totality of the statutory scheme.

The general purpose of the Social Security Act amendments which established Medicare was to create a system of medical insurance, just as the Act itself provides retirement insurance, for individuals eligible for social security benefits.[110] Like any insurance agreement, the legislative contract embodied in the Act is primarily concerned with defining the respective rights and duties of the governmental insuror and the insured beneficiaries.

For its part, the government is obligated to provide specified medical benefits to senior citizens eligible to participate by virtue of prior contributions to the program through payroll taxes which are in the nature of insurance premium payments. All those who meet the eligibility requirements are entitled, under Part A of the program which concerns us here, to in-patient hospital services, post-hospital extended care services and post-hospital home

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[109] Section 1102 provides:

> "The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education and Welfare, respectively, shall make and publish such rules and regulations, *not inconsistent with this chapter*, as may be necessary to the efficient administration of the functions with which each is charged under this chapter.

42 U.S.C. § 1302 (1970) (emphasis added). Section 1871 provides, in pertinent part:

> "The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. . . ."

42 U.S.C. § 1395hh (1970).

[110] 42 U.S.C. §§ 426, 402 (1970).

health services.[111] As with most insurance plans, the kind of medical service and the maximum duration of payments are subject both to general limitations,[112] and to specific exclusions from coverage,[113] including one for services "not reasonable or necessary" that is the basis of the controversy here.[114]

The proprietary right corresponding to the governmental obligation is not left unprotected by the Act. In recognition of the accrued interest of former payroll taxpayers to Medicare benefits, Section 1869 provides a right to a hearing and judicial review not only in disputes over eligibility for enrollment in the program, but also, within certain monetary limitations, in controversies over the "amount of benefits" payable.[115] Subject to the applicable dollar limitations, therefore, hearing and appeal may be obtained by a beneficiary dissatisfied with coverage determinations that operate to reduce the amount of his benefits.[116]

By authorizing individual consideration of all Medicare controversies under Part A over the proper amount of benefits, therefore, Section 1869 of the Act mandates a

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[111] Supplemental benefits may be obtained on a voluntary basis under Part B of the program through payment of a minimal monthly premium. 42 U.S.C. § 1395j et seq. (1970).

[112] 42 U.S.C. § 1395d (1970).

[113] 42 U.S.C. § 1395y (1970).

[114] 42 U.S.C. § 1395y(a)(1) (1970).

[115] 42 U.S.C. § 1395ff(b) (1970).

[116] Although agency policy on beneficiary appeals was not formally codified by the Secretary until 1972, the regulations now expressly recognize a beneficiary's right to appeal any issue "having a present or potential effect on the amount of benefits to be paid under Part A," 20 C.F.R. § 405.704(1) (1973), including the "coverage of items and services furnished," 20 C.F.R. § 405.704(a) (1973), and the "medical necessity of services." 20 C.F.R. § 405.704(k) (1973).

case-by-case review of disputes over coverage. If the Secretary determines that he must decline to pay for certain services on the ground that they are not medically reasonable or necessary, he must so inform the beneficiary in order that hearing and appeal rights may be exercised. Thus, the primary parties to a dispute over coverage are the Secretary and the individual beneficiary.

By comparison, providers of services like Mount Sinai play an incidental, if important, role in the Medicare program generally, and in disputes over coverage between the governmental insurer and beneficiaries in particular. Section 1802 of the Act is designed to assure maximum freedom to individual beneficiaries in securing health care from institutions of their own choosing.[117] The only limitation on their choice is that the institution selected must have met the minimal requirements for participation in the Medicare program as a provider of services.[118] Thus, Medicare patients stand in much the same relationship to providers of services as do patients with private medical insurance. They request medical services and become obligated to pay for those determined not to be covered by the program.[119]

As is true of the role of hospitals under private medical insurance plans, providers of services under Medicare have nothing whatever to do with disputes between the governmental insuror and the beneficiary over whether services rendered are, or are not, covered by the program. Section 1869 of the Act, which provides hearings and appeals in such disputes for the beneficiary, confines providers of services to appeals directly affecting their eligibility to furnish services under the Medicare program.[120]

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[117] 42 U.S.C. § 1395a (1970).

[118] 42 U.S.C. § 1395cc (1970).

[119] 42 U.S.C. § 1395cc(a)(2) (1970).

[120] 42 U.S.C. § 1395ff(c) (1970).

However, providers of services do have an interest in Medicare coverage disputes beyond that which they would have if a private insuror were involved. Section 1866 of the Act requires health care facilities to agree, as a condition of their participation in the program, not to charge Medicare beneficiaries for covered services.[121] Violation of this agreement is grounds for termination of a provider.[122] Yet Medicare beneficiaries may be charged by providers for services that are not covered by the program.[123] Consequently, a provider's ability to collect from an individual beneficiary without threat of termination depends upon the resolution of the coverage issue.

Of course, some coverage questions may be determined by a provider at the time of a patient's discharge without fear of jeopardizing its status as a Medicare provider. Thus, it is a relatively straightforward matter at the time of a beneficiary's release for providers to compute charges for the non-covered Medicare deductibles specified by the Act.[124] But it is quite a different matter for a provider to attempt to determine at time of discharge whether services rendered are excluded from coverage because they are "not reasonable or necessary."[125] The Medicare program, as originally enacted, placed its reliance on the attending physician to determine in the first instance whether services provided were "medically required and . . . neces-

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[121] 42 U.S.C. § 1395cc(a)(1)(A) (1970).

[122] 42 U.S.C. §§ 1395cc(a)(1)(A), 1395cc(b)(2) (1970); 20 C.F.R. §§ 405.614(a)(1), 405.607(a)(1) (1973).

[123] 42 U.S.C. § 1395cc(a)(2) (1970).

[124] 42 U.S.C. § 1395cc(a)(2)(A) (1970). Because of the possibility of computational errors, Section 1866 requires providers "to make adequate provision for return . . . of any moneys incorrectly collected from [an] individual" beneficiary. 42 U.S.C. § 1395cc(a)(1)(B) (1970).

[125] 42 U.S.C.§ 1395y(a)(1) (1970).

sary" to the beneficiary's diagnosis or treatment.[126] Consequently, a hospital may ignore the medical determination of the treating physician and bill a Medicare patient for such services at the time of his discharge only at the risk of termination from the Medicare program.

Providers are therefore not free to charge Medicare beneficiaries at the time of their release for services which may become the subject of a coverage dispute. Consequently, where a controversy over coverage arises between the Secretary and a beneficiary, the provider must be paid for its services at some point. The question is when and by whom. The logic of defendants' position compels the answer that payment may initially be made to the provider by Medicare, but that it will be subject to recoupment if, after hearing and appeal, the services rendered are finally determined to fall beyond the scope of the program's coverage. The provider would then presumably be left to its own devices to collect from its former patient.

Such an interpretation of the Medicare amendments presents at least three major difficulties. In the first place, if Congress had intended that Medicare operate in the manner suggested, participation in the program as a provider of services would be economically irrational. Providers would be confronted with the problems of collecting from beneficiaries for services long since rendered because of the delays in resolution of coverage disputes, delays which might amount to a matter of years for disputes over sizable sums for which judicial review is available. In view of the advanced age and precarious health of the beneficiary population, such delays could jeopardize a provider's ability to collect for its services. Because of this ultimate uncertainty that payment could be obtained, health care facilities would be discouraged from joining Medicare,

[126] 42 U.S.C. § 1395f(a)(2)(A) (Supp. I, 1965), as amended 42 U.S.C. § 1395f(a)(3) (1970).

thereby defeating the basic program objective of making health care widely available to eligible beneficiaries.

Secondly, such a system of payment followed by recoupment, if it would not be wasteful of administrative time and effort, does not square with the Act's procedure for resolving coverage disputes. The provider's interest in the coverage issue would be direct and immediate because it would stand to lose a Medicare payment previously received. The beneficiary's interest would be remote by comparison because unlike an individual privately insured, he would not himself first have to pay the hospital, then seek to recover from his insuror. Yet despite the substantial interest providers would have in the outcome of coverage disputes under such a system, the Act excludes them entirely from the coverage determination process.

Lastly, if it had indeed been the intent of Congress to leave the interest of providers in securing payment for their services unprotected where coverage questions arise, it is difficult to explain the Act's solicitude for that interest in special situations. Thus, Section 1814 expressly provides that a hospital is entitled to receive payments from Medicare for services rendered in good faith to a beneficiary before it is notified that its patient's in-hospital stay has exceeded the limtis of the program's coverage due to prior stays in other hospitals.[127] Similarly, Section 1866 authorizes the Secretary to decide to stop payments for any long-stay patients in lieu of terminating providers that fail to make timely review of such cases, but only after reasonable notice and opportunity for a hearing on his decision, and only if payment is made for an initial period of care.[128]

Even if the foregoing difficulties with defendants' position could be overlooked, we may not ignore one salient

[127] 42 U.S.C. § 1395f(e) (1970).

[128] 42 U.S.C. § 1395cc(d) (1970).

fact. The Medicare amendments make it clear that Congress did not intend to require providers to await notification of the final outcome of coverage disputes before attempting to collect from beneficiaries as best they can. Rather than leave to administrative discretion the related questions of when and from whom a provider may obtain payment in case of a coverage dispute, Section 1862 provides a simple answer: Medicare payments to providers may not be made at any time for services which are not covered.[129] If Medicare intends to dispute an item or service arguably excluded from coverage by Section 1862(a), therefore, it must refuse to pay when first billed by the provider.[130]

That this was the intent of Congress is evidenced by a distinction between exclusions from coverage drawn by the Medicare amendments. Unlike Section 1862(a) with which we are here concerned, Section 1862(b) expressly authorizes provisional payments to providers of services subject

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[129] The statutory language of Section 1862(a) pertinent to defendant's charge of overutilization is clear and direct:

> "Notwithstanding any other provision of this subchapter, *no payment may be made* under part A or part B *for any expenses incurred* for items or services—
>
> "(1) *which are not reasonable and necessary* for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

42 U.S.C. § 1395y(a)(1) (1970) (emphasis added). As originally enacted, Section 1862 (a) proceeded to enumerate eleven other basic exclusions from Medicare coverage.

[130] The provider can therefore proceed immediately to charge its Medicare patient for the disputed services without risk of termination of its status for collecting for covered services and without the prejudice to its ability to collect that might be occasioned by a lengthier delay.

to subsequent recoupment.[131] Advancement of such funds is limited, however, to cases in which payment from a state or federal workmen's compensation plan cannot reasonably be anticipated at the time Medicare receives the provider's bill. Moreover, Section 1862(b) forbids recoupment until the provider has actually obtained payment for its services, thereby protecting it from any of the uncertainties of collection.

Yet neither the provisional payment and recoupment procedure, nor its safeguards, are to be found among the remaining exclusions from coverage contained in Section 1862(a). If Congress had intended such a procedure to apply to them, much less to authorize the adaptation of one by administrative fiat, the statute would so provide. Thus, not only is the legislative intent of Section 1862(a) readily discernible from the language employed, the time-honored maxim of statutory construction that "expressio unius est exclusio alterius" compels the conclusion that the recoupment procedure advanced by defendants is inconsistent with the Medicare amendments. FTC v. Sun Oil Co., 371 U.S. 505, 514-515, 83 S.Ct. 358, 9 L.Ed.2d 466 (1963); J. Ray McDermott & Co. v. Vessel Morning Star, 457 F.2d 815, 818 (5th Cir. 1972) (en banc), cert. denied 409 U.S.

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[131] Section 1862(b) provides:

> "Payment under this subchapter may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. *Any payment* under this subchapter with respect to any item or service *shall be conditioned on reimbursement* to the appropriate [part A or part B] Trust Fund established by this subchapter *when notice* or other information *is received that payment* for such item or service *has been made* under such a law or plan."

42 U.S.C. § 1395y(b) (1970) (emphasis added).

948, 93 S.Ct. 292, 34 L.Ed.2d 218; Bott v, American Hydrocarbon Corp., 458 F.2d 229, 233 (5th Cir. 1972).

We conclude, therefore, that the Act bars provisional payments subject to recoupment from the provider if Medicare subsequently determines that the services rendered are excluded from coverage by Section 1862(a). It follows from the prohibition on recoupment that payment of charges for items or services constitutes a final determination as to the provider that they are not excluded by Section 1862(a) from coverage.[132]

Likewise, the ban on provisional payments in Section 1862(a) encompasses any scheme of administrative adjustments to recover payments erroneously made to providers for items or services it excludes from coverage. Defend-

[132] We note that payment for items or services does not necessarily represent a final coverage determination as to the beneficiary. If payment of a provider's charges is refused by Medicare, of course, the initial determination that the items or services are excluded from coverage by section 1862(a) does not become final until the beneficiary has exhausted such rights as he may have under section 1869 to administrative hearing and judicial review. If payment is made, on the other hand, the question is more difficult.

Mount Sinai suggests that Medicare can recover from the beneficiary for a mistaken payment to a provider for non-covered services under authority of Sections 1869 and 1870 of the Act. 42 U.S.C. §§ 1395ff. 1395gg (1970). Section 1869, however, simply authorizes appeals by beneficiaries from adverse "determinations"; it does not provide authority for reopening and reversing a prior determination that an item or service is covered by Medicare. Similarly, although Section 1870 requires that recovery must be sought first from the provided, then from the beneficiary where "more than the correct amount is paid," it does not itself authorized the determination of the correct amount. We think the provision in Section 1862(a) that "no payment may be made" for excluded items or services must be understood to protect beneficiaries as well as providers, absent an express indication to the contrary, from the reopening of coverage determinations due to prior mistakes in the payment of providers.

ants' reliance on Section 1815 as authority for adjustments in payments to correct erroneous coverage determinations is therefore misplaced. Section 1815, a cost provision permitting adjustments to correct overpayments resulting from regular interim payments of estimated costs, cannot authorize what Section 1862(a) forbids in determinations of coverage.

Coverage determinations and cost determinations therefore can be seen to derive from two separate grants of authority in the Act which differ significantly and do not overlap. Once payment for an item or service is extended, Section 1862(a) prohibits any effort to reopen the coverage determination and retrieve the payment from the provider. However, the Secretary is authorized by Section 1815 to adjust the amount of the payment for such a covered item or service in order to square it with a subsequent determination of the reasonable cost which the provider may properly charge.

This fundamental distinction between coverage and cost determinations is totally ignored by the suspension order issued to Mount Sinai on May 10, 1973 and by the regulations on which it was based. The challenged regulations were applied in this case to recoup payments made to plaintiff between 1966 and 1972 for items or services subsequently alleged to be excluded from Medicare coverage by Section 1862(a). Because a coverage, not a cost determination is at issue, Section 1815 provides no authority for application of the suspension regulations. Nor can the agency's broad discretion under Sections 1102 and 1871 to make rules necessary to the administration of the program expand the grant in Section 1815 to authorize what is not only inconsistent with, but forbidden by Section 1862(a). We hold. therefore, that the suspension order was unauthorized by the Act, and that application of the suspension regulations to recoup the payments made from July 1, 1966, through December 31, 1971, to providers for items or serv-

ices allegedly excluded from coverage by Section 1862(a) lacked statutory authority.

We are encouraged in this construction by the 1972 amendments to the Social Security Act,[133] which expressly provide both the statutory authority and procedural means for correcting abuses of the Medicare program by providers of services.[134] Effective October 30, 1972,[135] providers have been required to submit evidence to the Professional Standards Review Organizations (PSRO's) created by the amendments to document their obligatory assurances that services rendered meet professionally recognized standards of quality and are provided only when and to the extent medically necessary.[136] Upon receipt of a PSRO determination that a provider has been unwilling or unable to meet its obligation to avoid overutilization,[137] the Secretary may terminate the provider from the Medicare program,[138] or recoup amounts of up to $5,000 previously paid for such unnecessary services.[139] In either case, the amendments insure that the provider will be accorded the pro-

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[133] Act of Oct. 30, 1972, Pub.L.No. 92-603, Title II, § 249F(b), 86 Stat. 1442, amending 42 U.S.C. § 1320 (1970) (codified at 42 U.S.C. § 1320c (Supp. II, 1972)).

[134] 42 U.S.C. § 1320c-9 (Supp. II, 1972).

[135] The amendments have only prospective effect, and therefore do not apply to the present controversy. *See* note 6 *infra*.

[136] 42 U.S.C. § 1320c-9(a)(1) (Supp. II, 1972).

[137] 42 U.S.C. § 1320c-6 (Supp. II, 1972).

[138] 42 U.S.C. § 1320c-9(b)(2) (Supp. II, 1972).

[139] The amendments explicitly authorize recoupment by set-off:

> "Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed."

42 U.S.C. § 1320c-9(b)(3) (Supp. II, 1972).

cedural safeguards of an administrative hearing and judicial review.[140]

In enacting the 1972 amendments, moreover, Congress recognized the Secretary's previous lack of authority under the Act either to impose sanctions for overutilization or to recover payments made to providers for unnecessary services. The legislative history directly expresses a concern for this hiatus in the statutory scheme.[141] Of course, such interpretive pronouncements accompanying subsequent amendments to a statute do not provide a consistently reliable basis for inferring the intent underlying a prior Act of Congress, and we need not rely on them here. Waterman S. S. Corp. v. United States, 381 U.S. 252, 269, 85 S.Ct. 1389, 14 L.Ed.2d 370 (1965); United States v. Price, 361 U.S. 304, 312, 80 S.Ct. 326, 4 L.Ed.2d 334 (1960). Nonetheless, they have been accorded at least some consideration in this circuit as a "secondarily authoritative

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[140] 42 U.S.C. § 1320c-9(b)(4) (Supp. II, 1972).

[141] The report of the Senate Finance Committee states:

> "*Present law does not authorize the Secretary to withhold future payments for services furnished* by an institutional provider of services, a physician, or any other supplier who either abuses the program or endangers the health of beneficiaries, *although payment for past or current claims may be withheld on an individual basis* where the services are not reasonable or necessary for treatment of illness or injury or where the supplier fails to provide the necessary payment information."

S.Rep.No.92-1230, 93rd Cong., 2d Sess. 200 (1972) (emphasis added). As the report recognized, therefore, although the Secretary had been authorized by Section 1814 to withhold payment on account of overutilization on a case-by-case basis as he processed individual claims, 42 U.S.C. § 1395f(a) (1970), he lacked statutory authority to withhold payment of future claims for medically necessary services in order to recoup past overpayments resulting from program abuses.

expression of expert opinion." Bobsee Corp. v. United States, 411 F.2d 231, 237 n. 18 (5th Cir. 1969).[142]

Because of the view we take on the issue of statutory authority, we need not reach the question of the constitutionality of the suspension regulations. Mount Sinai is entitled to judgment on the merits and to a permanent injunction prohibiting unauthorized efforts by the Secretary or his agents to recoup Medicare payments the hospital received prior to January 1, 1972, on the basis of a subsequent determination that the items or services rendered were excluded from Medicare coverage by Section 1862(a) of the Act. Plaintiff shall therefore prepare in accordance with this opinion a final judgment with fees and costs taxed according to law. It is so ordered.

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[142] *Cf.* Red Lion Broadcasting Co. v. FCC, 395 U.S. 367, 380-381, 89 S.Ct. 1794, 23 L.Ed.2d 371 (1969); FHA v. Darlington, Inc., 358 U.S. 84, 90, 79 S.Ct. 141, 3 L.Ed.2d 132 (1958).

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No. 75-1041

In the Supreme Court of the United States

OCTOBER TERM, 1975

MT. SINAI HOSPITAL OF GREATER MIAMI, INC.,
PETITIONER

v.

F. DAVID MATHEWS, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINION BELOW

The opinion of the court of appeals (Pet. App. 1a–26a) is reported at 517 F. 2d 329. The opinion of the court denying rehearing (Pet. App. 27a–28a) is reported at 522 F. 2d 179. The opinion of the district court (Supplemental Appendix to the petition) is reported at 376 F. Supp. 1099.

JURISDICTION

The judgment of the court of appeals was entered on August 8, 1975. A timely petition for rehearing was denied on November 3, 1975. The petition for a

writ of certiorari was filed on January 22, 1976. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

QUESTION PRESENTED

Whether the Secretary of Health, Education, and Welfare may recoup payments made to a medicare provider for services subsequently determined to have been unnecessary and not covered by the Act.

STATUTES INVOLVED

Section 1815 of the Social Security Act, as added, 79 Stat. 297, 42 U.S.C. 1395g, and the relevant portions of Section 1866 of the Act, as amended, 86 Stat. 1394, 42 U.S.C. (Supp. IV) 1395cc, are set forth in the App., *infra,* pp. 13–14. The other relevant sections of the Act are set forth at Pet. App. 29a–38a.

STATEMENT

1. The Health Insurance for the Aged Act ("Medicare"), 42 U.S.C. 1395 *et seq.*, was enacted in 1965 in part to provide federal funding of the cost of certain hospital services afforded many individuals aged 65 and over. The Secretary of Health, Education, and Welfare, normally acting through private organizations, called "fiscal intermediaries," reimburses participant hospitals, called "providers," for the services they provide to eligible medicare beneficiaries. 42 U.S.C. (Supp. IV) 1395h and 1395i. Only bills in respect of services that were "reasonable and necessary for the diagnosis or treatment of illness or injury * * *" (42 U.S.C. 1395y(a)(1)) are subject to reimbursement. Moreover, reimbursement is limited to

the "reasonable cost" of the services. 42 U.S.C. (Supp. IV) 1395f(b).

In order to accommodate providers' cash flow requirements, the Act provides for reimbursement on an interim, pre-audit basis, not less often than monthly. 42 U.S.C. 1395g. The interim payments are based upon billings from the provider that have been preliminarily determined by the Secretary or a fiscal intermediary to contain charges for the reasonable cost of providing services covered by the Act. At the close of a provider's fiscal year, the Secretary undertakes an audit to determine the actual amount of reimbursement to which the provider was entitled for that year. If the audit reveals that the interim payments made during the fiscal year exceeded the amount to which the provider was entitled, the Secretary adjusts the provider's current interim reimbursement in order to recoup the excess payments. 42 U.S.C. 1395g.

2. Petitioner, Mount Sinai Hospital of Greater Miami, participates in the medicare program as a provider of services. In early 1972, petitioner's fiscal intermediary, respondent Blue Cross of Florida, Inc., determined to investigate allegations that petitioner had received payment under the Act for services that were not medically necessary. As a result of a preliminary review undertaken in June 1972, Blue Cross determined that a more detailed audit was required (J. App. 93–94).[1] Blue Cross and petitioner agreed that the audit would be conducted by reviewing patient

[1] "J. App." refers to the Joint Appendix to the briefs filed in the court of appeals.

records for a representative year and applying the statistical results of that review to the years 1966 through 1971 (J. App. 94–95, 109–110).

The patient records for the representative year were reviewed twice under the auspices of the Peer Review Committee of the Florida Medical Foundation, an affiliate of the Florida Medical Association (J. App. 95, 96). Some 45 physicians, divided according to specialty into groups of three or four, were presented with the charts of patients who had received care in the group's area of expertise (J. App. 95–96). If all physicians in the reviewing group agreed that the services rendered to a patient were medically unnecessary, they made a recommended finding to that effect (J. App. 96).

On March 23, 1973, Blue Cross notified petitioner that, on the basis of the recommendations of the Peer Review Committee, it had determined that approximately $6 million of petitioner's reimbursed services had been medically unnecessary and that it proposed to institute suspension of 15% of the current amounts due petitioner until the $6 million in overpayments had been recouped (J. App. 97). After two meetings between petitioner and Blue Cross (J. App. 98, 118), and consideration of two written statements submitted by petitioner (J. App. 99, 101), Blue Cross prepared a written statement containing specific findings and conclusions as to the existence of an overpayment and the need for a 15% suspension of current payments due petitioner to protect the medicare program against financial loss (J. App. 105–106; see 20 C.F.R. 405.372).

3. Petitioner thereupon instituted this action in the United States District Court for the Southern District of Florida, contending, *inter alia,* that the Secretary lacked statutory authority to recoup payments made for services subsequently determined not to have been covered by the Act and that, in any event, the suspension of current payments constituted a denial of due process.

The district court denied the government's motions to dismiss and for summary judgment, and granted petitioner's motion for summary judgment on the ground that the Secretary lacked authority to recoup payments erroneously made for services subsequently determined to have been medically unnecessary (Pet. Supp. App. 47a, 68a).[2] The court reasoned that Congress had expressly authorized recoupment of payments in excess of the "reasonable cost" of the services rendered and therefore must be presumed to have withheld authorization to recoup other erroneous payments (Pet. Supp. App. 50a–55a, 64a–65a). The court therefore did not reach petitioner's due process claim (Pet. Supp. App. 68a).

The court of appeals reversed. The court held that the Secretary had a common-law right to recoup payments erroneously paid by him for non-covered serv-

[2] In the motion to dismiss, the government contended, *inter alia*, that the court lacked subject matter jurisdiction over the lawsuit. The argument was based primarily on Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), incorporated by reference in the Medicare Act (42 U.S.C. 1395ii), which states that no decision of the Secretary shall be reviewed except as provided by the Act. Cf. *Weinberger* v. *Salfi*, 422 U.S. 749.

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ices, finding both in the Medicare Act and its 1972 amendments an understanding on the part of Congress that the Secretary had such a right (Pet. App. 12a–24a). The court remanded the case to the district court for consideration of petitioner's other claims (Pet. App. 26a).

ARGUMENT

The decision below is correct and no further review is warranted. The Secretary's common-law right to recoup monies erroneously paid is well established, and nothing in the Medicare Act either expressly or by implication abrogates that right. There is no conflict among the courts of appeals on the issue.[3]

1. As both courts below recognized (Pet. App. 8a–9a; Pet. Supp. App. 48a), the government has inherent authority to recover funds illegally or erroneously paid.[4] *E.g., United States* v. *Carr,* 132 U.S. 644; *Wisconsin Central Railroad Co.* v. *United States,*

[3] Moreover, petitioner's other claims have been remanded for consideration by the district court; determination of those claims in petitioner's favor in the district court might render moot the principal question raised by petitioner here. Although petitioner seeks to raise those other claims here as well (Pet. 30–32), since they have not yet been considered by the lower courts they are plainly not ripe for review.

[4] The court of appeals rejected the government's contention that Section 1815 of the Social Security Act, 42 U.S.C. 1395g, affirmatively authorizes the Secretary to recoup payments for non-covered services (Pet. App. 6a–7a). That provision entitles the Secretary to adjust current payments "on account of previously made overpayments or underpayments * * *," without distinguishing among various kinds of overpayments; yet the court of appeals held that Section 1815 applies only to payments in excess of the reasonable cost of services. It is the government's position that Section 1815 authorizes the recoupment at issue here. However, as an alternative, the government supports the reasoning of the courts of appeals

164 U.S. 190; *Heidt* v. *United States,* 56 F. 2d 559, 560 (C.A. 5), certiorari denied, 287 U.S. 601; *United States* v. *Paddock,* 178 F. 2d 394, 396–397 (C.A. 5), rehearing denied, 180 F. 2d 121, certiorari denied, 340 U.S. 813. The United States may exercise this right by deducting or withholding the amount of the overpayment from other sums due to the recipient. *E.g., United States* v. *Munsey Trust Co.,* 332 U.S. 234, 239–240; *Gratiot* v. *United States,* 15 Pet. 336; *McKnight* v. *United States,* 98 U.S. 179, 186; *Wisconsin Central Railroad Co.* v. *United States, supra.*

The right of recoupment is independent of statute. *E.g., United States* v. *Wurts,* 303 U.S. 414, 416; *Grand Trunk Western Ry. Co.* v. *United States,* 252 U.S. 112, 121; *United States* v. *Bank of the Metropolis,* 15 Pet. 377, 401. It is abrogated only where Congress has clearly manifested its intention to do so. *United States* v. *Wurts, supra.*[5]

The Medicare Act evinces a congressional understanding that the Secretary would retain the common-law right of recoupment. Section 1870 of the Act, 42

that the Secretary's common-law right of recoupment has not been abrogated by the Medicare Act.

[5] Petitioner contends (Pet. 29–30) that even if the Secretary possessed the common-law right to recoup funds paid under the Medicare Act, the right is not applicable here since the right does not apply to payments made as the result of an error in judgment. However, as the court of appeals correctly noted (Pet. App. 9a–10a), the Medicare Act expressly prohibits payments for services which are not medically necessary. 42 U.S.C. 1395y(a)(1). The determination whether payment has been made in violation of this prohibition is to be made by the Secretary. See *Association of American Physicians and Surgeons* v. *Weinberger,* 395 F. Supp. 125 (N.D. Ill.), affirmed, November 18, 1975 (No. 75-361).

U.S.C. 1395 gg, prior to its amendment in 1972 (see p. 11, *infra*) authorized the Secretary to recoup from a beneficiary an overpayment made to a provider, but only when "the excess * * * amount cannot be recouped from [illegible] such provider of services * * *." 42 U.S.C. 1395gg(b)(1).[6] As the court of appeals demonstrated (Pet. App. 12a–13a), this provision is premised upon the existence of authority in the Secretary to recoup funds paid to a provider. Petitioner contends (Pet. 28–29) that Section 1870 is limited to the recovery of payments made in excess of the reasonable cost and does not extend to payments erroneously made for non-covered services.[7] But the statute explicitly refers to any situation "[w]here * * * more than the correct amount is paid under this [Act] * * *." Nothing in this language distinguishes between unreasonable costs and unnecessary services.

This view of the congressional understanding is confirmed by the 1972 amendments to the Medicare Act, which, *inter alia,* bar a provider from charging beneficiaries, not themselves at fault, for services determined by the Secretary, more than three years after the original payment to the provider, not to

[6] Petitioner contends (Pet. 28) that Section 1870 applies only to claims other than those arising under the Medicare Act, *e.g.*, the False Claims Act, 31 U.S.C. 231. Nothing in the language or history of the Act supports this contention.

[7] Under petitioner's theory, if the Secretary pays a claim of two dollars for two doses of medication furnished to a beneficiary, he can recoup one dollar from the provider if he subsequently determines that one dollar represents the "reasonable cost" of the medication but not if he determines that one of the doses was not medically necessary.

have been covered by the Medicare Act. 42 U.S.C. (Supp. IV) 1395cc(a)(1)(B). As the court of appeals correctly pointed out (Pet. App. 21a):

> This kind of protection would not be necessary unless (1) providers could be required to reimburse HEW for money received in payment for non-covered services, and (2) the determination of non-coverage could be made after the original [prepayment] determination * * *, indeed, more than three years after that determination.

Although the 1972 amendments were enacted after the years in issue here,[8] they are probative of Congress' understanding of the Secretary's recoupment right under the Medicare Act. The amendments and their legislative history (see, *e.g.,* S. Rep. No. 92–1230, 92d Cong., 2d Sess. 313 (1972), quoted from at Pet. App. 19a) indicate that Congress assumed that providers were liable to the Secretary for payments erroneously made for non-covered services.[9] This congressional understanding is entitled to "great weight" in construing the statute. *Red Lion Broadcasting Co.* v.

[8] Thus to the extent that petitioner might claim that the 1972 amendments enlarged the Secretary's recoupment rights, this case would lack prospective importance, for it would relate only to recoupment rights with regard to pre-1972 overpayments.

[9] In 1972, Congress also amended the Medicaid Act to provide that the Secretary could order a cessation of payments to a hospital under that Act if the hospital has terminated its participation in the medicare program and the Secretary is unable to recover an overpayment made to the hospital under the Medicare Act. 42 U.S.C. (Supp. IV) 1396b(j)(2)(B)(i). This further indicates that Congress understood the Secretary to possess the right to recoup overpayments by withholding equivalent sums from amounts currently due.

Federal Communications Commission, 395 U.S. 367, 380–381.

2. Petitioner contends that the right of recoupment conflicts with Section 1869 of the Act, 42 U.S.C. (Supp. IV) 1395ff (Pet. 23–27), and is harsh in operation (Pet. 15–19).

a. Section 1869 of the Act merely establishes procedures by which a beneficiary may contest the Secretary's decision that a service provided to the beneficiary was not covered under the Act.[10] Petitioner argues that the existence of such procedures, which could be invoked, for example, when a fiscal intermediary refused payment of a claim initially, precludes recoupment of erroneous payments of claims. But the fact that a beneficiary is entitled to review when the Secretary refuses to pay a claim in the first instance is in no way inconsistent with the Secretary's right to recoup money that he subsequently discovers to have been erroneously paid.[11] The Act explicitly contemplates post-payment reconsideration of the correctness of payments (see, *e.g.*, 42 U.S.C. 1395g and (Supp. IV) 1395cc), and petitioner's argument to the contrary is insubstantial (see Pet. App. 17a–18a). Moreover,

[10] Congress has now granted providers standing to participate in the administrative proceedings and a limited right to judicial review. 42 U.S.C. (Supp. IV) 1395pp.

[11] Petitioner incorrectly contends (Pet. 22–23) that the decision of the court of appeals is inconsistent with 42 U.S.C. 1395f(a)(7), which permits payment for certain unnecessary services for a limited grace period. Although that provision may bar recoupment of particular payments made with respect to certain unnecessary services, by preventing such payments from being treated as overpayments under the Act, it obviously does not affect the Secretary's right to recoup overpayments not so protected.

petitioner's argument that the Secretary is irrevocably bound by the initial decision to make interim reimbursement would, if sustained, enormously increase both the potential for abuse and the difficulty of making initial determinations.

b. Petitioner also contends that providers should not be subject indefinitely to the possibility of recoupment. That, however, is a matter for Congress to consider, as it evidently did in 1972 in providing that recoupment is permissible only when the provider was not without fault and that the provider is rebuttably presumed to be without fault when the determination of overpayment is made more than three years after payment. 42 U.S.C. (Supp. IV) 1395gg(b); see Pet. App. 18a, n. 22. Congress did not, however, choose to abrogate the government's right under common law to recoup erroneous payments (see pp. 6–10, *supra*), and it is not the province of the judiciary to reverse that legislative policy judgment.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted.

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MARCH 1976.

APPENDIX

Statutes Involved

42 U.S.C. 1395g provides:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any period.

42 U.S.C. (Supp. IV) 1395cc(a)(1)(B) provides:

> (a)(1) Any provider of services (except a fund designated for purposes of section 1395f (g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement—
>
> * * * * *
>
> (B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may

not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter, * * *.

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No. 75-1041

In the Supreme Court of the United States

OCTOBER TERM, 1975

MT. SINAI HOSPITAL OF GREATER MIAMI, INC., PETITIONER

v.

F. DAVID MATHEWS, SECRETARY OF HEALTH, EDUCATION, AND WELFARE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

SUPPLEMENTAL MEMORANDUM FOR THE RESPONDENTS

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In its reply to our brief in opposition, petitioner incorrectly asserts (pp. 1-4) that our discussion of 42 U.S.C. 1395f(a)(7)[1] (Br. in Opp. 10, n. 11) amounts to a confession

---

[1]The statute was amended in 1972, in a manner that does not bear upon the discussion here. It now provides in pertinent part:

> * * * [P]ayment for services furnished an individual may be made * * * only if * * *
>
> (7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made * * * pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

of error. Since the statutory provisions relating to this case are complex, and petitioner's assertion might otherwise confuse the Court, we submit this rejoinder to clarify the matter.

It has been our position throughout this litigation that payments made by the Secretary in advance of any determination of non-necessity are subject to recoupment if it is subsequently determined that the services for which the payments were made were not medically necessary. Such payments are made erroneously, and recoupment is appropriate for the reasons stated in our brief in opposition.

Under 42 U.S.C. 1395f(a)(7), however, the Secretary has discretionary authority to pay for certain medically unnecessary inpatient hospital services, and post-hospital extended care services, for a period of three days after notice of the determination of non-necessity. Since such payments, if made, are not erroneous but instead represent a deliberate exercise of discretion, there is, as we indicated in the footnote on which petitioner relies, an open question whether their recoupment would later be permitted.

That question, however, is wholly irrelevant to this case. There is no indication in the record that any of the payments sought to be recouped here represented a deliberate exercise by the Secretary of his discretion to pay for services already determined to have been unnecessary. Accordingly, notwithstanding petitioner's late-blooming and unsupported assertion to the contrary (Pet. Reply Br. 3), the payments at issue here are not "protected under Sec. 1395f(a)(7)."

For the reasons stated above and in our brief in opposition, it is respectfully submitted that the petition for a writ of certiorari should be denied.

ROBERT H. BORK,
Solicitor General.

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FORREST D. MATHEWS, Secretary of Health, Education, and Welfare, and BLUE CROSS OF FLORIDA, INC.,
Respondents

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITIONER'S REPLY TO RESPONDENTS' BRIEF IN OPPOSITION

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PETITIONER'S REPLY TO RESPONDENTS' BRIEF IN OPPOSITION

The following is in reply to certain new matters raised by the Respondents' Brief in Opposition.

ARGUMENT

1. Respondents' Concession as to 42 U.S.C. 1395f(a)(7) Is, In Effect, a Confession of Error.

In their Brief in Opposition, Respondents, for the first time in this entire litigation, have attempted to

come to grips with Sec. 1395f(a)(7). In so doing, Respondents have conceded the significance of that section, which concession is, in effect, a confession of error.

Until now, Respondents have ignored Sec. 1395f(a)(7) and have argued simplistically and superficially as follows: (1) no payment may be made for medically unnecessary services because of Sec. 1395y(a)(1); (2) if a payment is made for an unnecessary service, it is an "overpayment"; (3) although Sec. 1395gg(a)(1)(A) provides that Medicare payments are deemed to have been paid to the patient, "overpayments" are to be deemed to have been made to the hospital; and (4) all "overpayments" may be recouped from the hospital, without limitation as to time or amount, under the theory of common law recoupment or under Sec. 1395g. In view of Sec. 1395f(a)(7), Respondents now effectively concede that this argument proves too much and is therefore wrong.

Sec. 1395x(k)(4) required a hospital's in-house utilization committee to screen the hospital services and notify both the hospital and the physician if it deemed the hospital stay or certain services to be unnecessary. Even if the hospital stay was then unnecessary, the hospital was still to be paid the reasonable cost of services actually rendered to an eligible beneficiary, not only for the time up to actual notice but also for a three day grace period thereafter, during which grace period the services could be terminated with the patient's and the physician's approval, or alternative payment arrangements could be made. What is of critical significance is that Sec. 1395f(a)(7) provides for a hospital to be paid, even for

medically unnecessary services, until it has notice and a subsequent grace period. This is not shocking since there is no evidence that Congress intended hospitals to bear the risk of a retroactive judgment on the medical necessity of a physician's instructions.

On page 10 in footnote 11 of its Brief, Respondents concede that, under Sec. 1395f(a)(7), payments for unnecessary services, prior to notice and the expiration of the grace period, are *not* "overpayments" under the Act; in this regard, that footnote states:

> * * * Although that provision [*i.e.*, Sec. 1395f(a)(7)] may bar recoupment of particular payments made with respect to certain unnecessary services, by preventing such payments from being treated as overpayments under the Act, it obviously does not affect the Secretary's right to recoup overpayments not so protected.

Admittedly then, to use Respondents' words, payments for Sec. 1395f(a)(7) services are "protected" against recoupment since they are not "overpayments."

In the case at bar, none of the $6.38 million includes payments made after such notice and grace period. To the contrary, all the payments in issue for the July 1, 1966 to December 31, 1971 time period (first questioned after 1971) are protected under Sec. 1395f(a)(7). Under Respondents own concession, therefore, there are no "overpayments" subject to recoupment, and that should dispose of this case. The only way in which the decision below can legitimately stand is to assume that every dollar paid for an unnecessary service may be recouped, because that is what Respondents argued below and what that Court held.

It would be absurd, however, to have a situation where the Respondents now admit that some (all in this case) payments are "protected" against recoupment, while arguing that the decision below subjects all such payments to recoupment.

2. Respondents' Position Compounds the Uncertainty as to the State of the Law.

Notwithstanding the fact that both Courts below held that Sec. 1395g permitted recoupment of only those "overpayments" resulting from year end cost accounting audit adjustments, Respondents continue to argue that it also permits recoupment of "overpayments" due to payments for unnecessary services. (Br. p. 6, fn. 4.) Sec. 1395g provides for payment "adjustments of previously made overpayments or underpayments", in the context of interim estimates of reasonable cost. Even if this section envisioned overpayments because of unnecessary services (as opposed to merely adjusting the year's costs attributable to covered services), Respondents have admitted that Sec. 1395f(a)(7) prevents the payments to Mt. Sinai from being treated as "overpayments." How then can Sec. 1395g apply; can a payment be not an "overpayment" for Sec. 1395f(a)(7) purposes but be an "overpayment" for Sec. 1395g purposes? Can it be protected from recoupment under one section but still be subject to recoupment under another section or common law? This confusion results from Respondents recognizing that Sec. 1395f(a)(7) prevents certain payments for unnecessary services from being considered recoupable "overpayments" while simultaneously and inconsistently urging that the decision below stand even though it held that *all* payments for

unnecessary services are "overpayments" subject to recoupment.

The confusion is compounded when Respondents quote from Sec. 1395gg(b)(1) which relates to situations where more than the "correct amount" is paid (Br. p. 8), and then sum up by arguing for a common law right to recoup "erroneous payments". (Br. p. 11.) Throughout their Brief, therefore, Respondents refer to "protected overpayments", "overpayments not so protected", "overpayments" without definition, payments in excess of the "correct amount" and "erroneous payments", which is not a statutory term. Where in all of this terminology do the payments to the many hospitals in Mt. Sinai's situation fall? This free wheeling and interchangeable use of statutory and non-statutory terminology, coupled with Respondents' position on Sec. 1395f(a)(7), leave totally in chaos the state of the law regarding Respondents' enforcement rights and the ability of hospitals to rely on past payments and approvals. If Respondents' position on Sec. 1395f(a)(7) is not, in effect, a confession of error, then we are left completely at sea as to what these various terms mean in the statutory context in which they appear.

This confusion affects not only all pre-1972 Medicare payments, which are forever open to question under the decision below, but also the administration of the law after the 1972 amendments. For example, neither Sec. 1395y(a)(1) nor Sec. 1395g was amended in 1972, and Respondents argue (Br. 11) that Congress did not intend to abrogate the common law right to recoup "erroneous payments". Still open, then, is the question of whether Respondents' term "errone-

ous payments" includes payments for unnecessary services which are not "overpayments" under Sec. 1395f(a)(7). Still another uncertainty is the notion of "fault" which, Respondents assert, Congress "evidently" legislated as a condition to recoupment; the use of the term "evidently" indicates a basic uncertainty, which uncertainty flows from Respondents adherence to its basic proposition that Secs. 1395g and 1395y(a)(1), plus the common law, combine to permit recoupment, notwithstanding other provisions of the Act indicating the contrary. And since Respondents expressly stated that they intend to pursue the same course of action for 1972 and thereafter, it cannot be said, as Respondents argue (Br. p. 9, fn. 8), that the issues here lack prospective importance.

3. The 1972 Amendments to 42 U.S.C. 1395cc(a)(1)(B) and to the Medicaid Act Do Not Nullify 42 U.S.C. 1395f(a)(7).

Respondents' reliance on Sec. 1395cc(a)(1)(B) assumes rather than proves their conclusion. (Br. p. 9) If, as Respondents suggest, Congress provided in 1972 for a "fault" standard of recoupment (Br. p. 11), then it is not surprising that it also provided for time limitations and for a hospital's rights over against patients. These amendments do not *per se* answer the questions of whether a right to recoup from a hospital on issues of medical necessity was made available in 1972 under a fault standard or whether a right was impliedly present without limitation since July 1, 1966.[1]

[1] It should be kept in mind that these 1972 amendments were enacted with, and should be read in the context of, the PSRO provisions relating to utilization.

Nor is Respondents' reference to the 1972 *Medicaid* amendments supportive of their position. (Br. p. 9, fn. 9.)[2] Those provisions do not acknowledge a then existing right in Respondents to recoup on the basis of medical necessity; they do no more than provide that *if there is a right* to recover Medicare funds on some basis, then Respondents may withhold Medicaid payments from a state.[3] The reference to the Medicaid Act, therefore, merely begs the question of when and under what circumstances Respondents may question the medical necessity for services *vis-a-vis* a hospital as opposed to a physician who prescribed the services or the patient. Certainly these amendments do not impliedly repeal Sec. 1395f(a)(7).

4. The District Court's Decision and Subject Matter Jurisdiction.

Respondents unfairly capsulize and depict the District Court's decision as being based solely on the reasoning that: "Congress had expressly authorized recoupment of payments in excess of 'reasonable cost' of the services rendered [*i.e.*, Sec. 1395g] and therefore must be presumed to have withheld authorization to recoup other erroneous payments * * *." (Br. p. 5.) To the contrary, the District Court's decision was based on far more elaborate reasoning than this, reflected by the following comment by that Court (Pet. Supp. App. 56a):

[2] This is cited as 42 U.S.C. (Supp. IV) 1396b(j)(2)(B)(i) but Respondents seemingly are referring to Sec. 1396b(l)(2)(B)(i).

[3] The overpayment referred to, in the context of other provisions of the Act, is one based on the year-end determination of actual reasonable costs, not on retroactive changes in judgments as to medical necessity.

> Nonetheless, upon careful consideration of the entirety of the Act, the Court is persuaded that the suspension regulations are fundamentally at odds with the intent of Congress as it is manifested by the totality of the statutory scheme.

Nor does Mt. Sinai agree with Respondents' version of the facts, which version is taken from Respondents' self serving and argumentative letter sent when suit was filed and never subjected either to discovery or trial.[4]

It is true that Respondents argued subject matter jurisdiction in the District Court, as well as a number of other points including the dilatory objection to actual personal service of the complaint on the theory that the Florida superintendent or commissioner of insurance should have been served instead. In any event, subject matter jurisdiction was not raised in the Court of Appeals nor do Respondents argue it here beyond the oblique reference to *Weinberger* v. *Salfi*, 422 U.S. 749. (Br. p. 5, fn. 2.) *Salfi* is clearly distinguishable since there the claimants had express administrative and judicial review procedures available under 42 U.S.C. Sec. 405(h); in the case of hospitals under Medicare, no such procedure is provided. In fact, Respondents have always contended that a hospital is not entitled to the procedures otherwise available to patients under 42 U.S.C. Sec. 1395ff and 20 C.F.R. 405.701 *et seq.*[5] While this Court may raise

[4] As one example, Respondents' assertion (Br. p. 4) that immediate suspension of payments was necessary to protect Medicare against financial loss was rejected by the District Court when it granted an interlocutory injunction.

[5] See Citation p. 23, fn. 17 for Respondents' position on the administrative rights of a provider.

the issue of jurisdiction *sua sponte*, it is not an appropriate issue here and *Salfi* is inapplicable. See also *Mathews* v. *Eldridge*, 424 U.S. ——, decided February 24, 1976.

CONCLUSION

A writ of certiorari should be issued to the Court of Appeals for the Fifth Circuit.

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